Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

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- A. The **State** of **Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Program Title:

Home and Community Based Services - Physical Disability Waiver

C. Waiver Number: IA.0345

Original Base Waiver Number: IA.0345.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
10/01/18

Approved Effective Date of Waiver being Amended: 11/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

- 1. This amendment does include changes to the performance measures; these measures were recently approved by CMS with the renewal of the Health & Disability Waiver.
- 2. reflect change of Responsibility for Service Plan Development from Social worker to case manager.
- 3. reflect new federal managed care regulations for processing member grievance and appeals through managed care organizations (MCO's).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A - Waiver Administration and Operation	Qulaity Improvemen
Appendix B - Participant Access and Eligibility	Quality Improvemen
Appendix C - Participant Services	Quality Improvemen
Appendix D – Participant Centered Service Planning and Delivery	Quality Improvemen
Appendix E - Participant Direction of Services	
Appendix F – Participant Rights	
Appendix G - Participant Safeguards	Quality Improvemen
Appendix H	Quality Improvemen
Appendix I – Financial Accountability	Quality Improvemen
Appendix J - Cost-Neutrality Demonstration	

	arrays
В.	Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment
	(check each that applies):
	Modify target group(s)
	Modify Medicaid eligibility
	Add/delete services
	Revise service specifications
	Revise provider qualifications

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Main Module	: Waiver Draft IA.001.04.01 - Oct 01, 2018	Page 2 of 14
Rev Add Oth Specimpl		S with the
Applica	tion for a §1915(c) Home and Community-Based Services	Waiver
1. Request I	nformation (1 of 3)	programme in the company of the comp
authority B. Program Home an	e of Iowa requests approval for a Medicaid home and community-based services (HCBS) we of §1915(c) of the Social Security Act (the Act). Title (optional - this title will be used to locate this waiver in the finder): ad Community Based Services - Physical Disability Waiver Request: amendment	aiver under the
	ed Approval Period:(For new waivers requesting five year approval periods, the waiver mals who are dually eligible for Medicaid and Medicare.)	usi serve
3 yes	ars 🖲 5 years	
Draft ID D. Type of V Regular E. Proposed	Waiver (select only one):	
1. Request Ii	nformation (2 of 3)	INCOME STATE OF THE PROPERTY O
individua which wo Hos Selec	of Care. This waiver is requested in order to provide home and community-based waiver see als who, but for the provision of such services, would require the following level(s) of care, to build be reimbursed under the approved Medicaid State plan (check each that applies): pital act applicable level of care Hospital as defined in 42 CFR §440.10 If applicable, specify whether the State additionally limits the waiver to subcategories of the of care:	the costs of
V Nur Sele	Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR sing Facility act applicable level of care Nursing Facility as defined in 42 CFR 440.40 and 42 CFR 440.155 If applicable, specify whether the State additionally limits the waiver to subcategories of the level of care:	
	CTOLOLOUGO.	A.
·**** \	Institution for Mental Disease for persons with mental illnesses aged 65 and older as p	remided in 42
· open	rustification for interies disease for betsons mith mental innesses aged as and older as i	noviulu IR 42

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR

CFR §440.140

§440.150)

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. Requ	est Information (3 of 3)	
pro	ncurrent Operation with Other Programs. This waiver operates concurrently with another program (or grams) approved under the following authorities ect one:	
, res. ,	Not applicable	
(Applicable	
	Check the applicable authority or authorities:	
	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I	
	Waiver(s) authorized under §1915(b) of the Act.	
	Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been	
	submitted or previously approved: Iowa High Quality Healthcare Initiative/Iowa HealthLink (effective 4.1.2016)	
	Specify the §1915(b) authorities under which this program operates (check each that applies):	
	§1915(b)(1) (mandated enrollment to managed care)	
	§1915(b)(2) (central broker)	
	§1915(b)(3) (employ cost savings to furnish additional services)	
	§1915(b)(4) (selective contracting/limit number of providers)	
	A program operated under §1932(a) of the Act.	
	Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been	
	submitted or previously approved:	-
		M
	A program authorized under §1915(i) of the Act.	
	A program authorized under §1915(j) of the Act.	
	A program authorized under §1115 of the Act.	
	Specify the program:	
		, T

2. Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods. Waiver Program Summary

The goal of the Iowa HCBS Physical Disability (PD) waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible participants may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet nursing facility (as defined in 42 CFR §440.40 and 42 CFR §440.155) level of care. IME's Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care revaluations for fee-for-service participants. MCOs are responsible for conducting level of care

reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, applicants are advised of the waiting list and that they may choose to receive facility-based services.

If the applicant is deemed eligible, necessary services are determined through a person centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the individual will have the option to choose between various traditional and self-directed services.

Services include consumer directed attendant care-unskilled care, consumer directed attendant care-skilled care, home and vehicle modification, specialized medical equipment, and transportation. Self-directed services include financial management, independent support brokerage, self-directed personal care, self-directed community and employment supports, and individual-directed goods and services.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentive Payment Program project, it is the goal of Iowa to significantly reduce wait lists and offer a more uniform and equitable system of community support delivery to individuals with physical disabilities.

3. Components of the Waiver Request

The waiver application consists of the following components. Note: Item 3-E must be completed.

- A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services. When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (Select one):
 - Yes. This waiver provides participant direction opportunities. Appendix E is required.

 No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan i)

	in Appendix B.
В.	Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i
	(III) of the Act in order to use institutional income and resource rules for the medically needy (select one):
	® Not Applicable
	O No
	○ Yes
C.	Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (select one):
	® No
	T Yes
	If yes, specify the waiver of statewideness that is requested (check each that applies): Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this
	waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
	Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
	Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to
	make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the
	service delivery methods that are in effect elsewhere in the State. Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 - 1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
 - 2. Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 - 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.
- B. Financial Accountability. The State assures financial accountability for funds expended for home and communitybased services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.

- C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.
- **D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 - 1. Informed of any feasible alternatives under the waiver; and,
 - 2. Given the choice of either institutional or home and community-based waiver services. Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.
- F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-1 must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in Appendix D. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- **B.** Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in Appendix C.
- E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. Appendix F specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in Appendix H.
- I. Public Input. Describe how the State secures public input into the development of the waiver:

 DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Mental Health Planning Council meets monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues.

The public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council. The IME also provides notice of applications and amendments by including notice in the IME e-News emails and on the IME website.

IME used the following processes to secure public input into the development of the PD Waiver Amendment:

1) IME Website Posting - The public notice and the PD Waiver mendment was posted to the DHS IME Website under the category, News & Initiatives (https://dhs.iow.gov/public-notices/XXXXX. The public posting period began XXXXXX, 2018 and ended XXXXX, 2018. The PD Waiver program manager did XXXX receive public comments during this period.

- 2) DHS Field Office Posting IME provides notification to the DHS Field Office, which in turn, notifies each DHS Field Office to post the Waiver Public Notice and to provide a copy of the CMS Waiver Amendment for any public request. The public posting period was the same for this process. The PD Waiver program manager did XXX receive public comments.
- 3) IME Public Notice Subscribers Medicaid members, Medicaid providers, legislators, advocacy organizations and others who wish to remain informed regarding Iowa Medicaid can subscribe to the IME Public Notice webpage. All subscribers will receive electronic notice whenever an update/public notice is posted. This process includes HCBS waiver renewals. The public posting period was the same for this process. The PD Waiver program manager did not receive public comments.
- 4) Iowa Tribal Nations Notification The IME Tribal Nations liaison notified all Nation governments by email on XXXX, 2018. The comment period ended on XXXX, 2018. The liaison did XXXX receive any comments or questions during this period.
- J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 August 8, 2003). Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

Last Name:	
	Howland
First Name:	
	Leann
Title:	
	Medicaid Program Manager
Agency:	
	Iowa Medicaid Enterprise/Iowa Department of Human Services
Address:	
	100 Army Post Road
Address 2:	
City:	
	Des Moines
State:	Iowa
Zip:	y-amount-ar-ar-ar-ar-ar-ar-ar-ar-ar-ar-ar-ar-ar-
	50315
The f	
Phone:	(515) 256-4642 Ext: TTY
	(OID) 200 TOTA

	Fax:	(515) 256-1306
	E-mail:	
	E SINFRAN	Ihowlan@dhs.state.ia.us
В.	If applicable, the	e State operating agency representative with whom CMS should communicate regarding the waiver is:
	Last Name:	
		Johnson
	First Name:	Deborah
	TT: A	Deboran
	Title:	Bureau Chief, Division of Long Term Care and Medical Supports
	Agency:	
	Angestey.	Iowa Medicaid Enterprise
	Address:	
		100 Army Post Rd.
	Address 2:	
	City:	
	_	Des Moines
	State:	Iowa
	Zip:	50315
	Phone:	promote an annual contract of the state of t
		(515) 256-4662 Ext: TTY
	Fax:	
		(515) 256-4626
	E-mail:	djohnso6@dhs.state.ia.us
8. Au	ithorizing Si	gnature
to ame	end its approved v waiver, including	r with the attached revisions to the affected components of the waiver, constitutes the State's request valver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions the provisions of this amendment when approved by CMS. The State further attests that it will
specifi	ied in Section VI	e waiver in accordance with the assurances specified in Section V and the additional requirements of the approved waiver. The State certifies that additional proposed revisions to the waiver request e Medicaid agency in the form of additional waiver amendments.
Signati	ure:	
		t.
		State Medicaid Director or Designee
Sphmi	ssion Date:	
ouding.	DELTH PART.	

	Note: The Signature and Submission State Medicaid Director submits the	Date fields will be automatically completed when the application.	
Last Name:			
First Name:			
Title:			y von anne
Agency:			Totalor
Address:			dir.
Address 2:			planter and
City:			
State:	Iowa	3	
Zip:			
Phone:		Ext: TTY	
Fax:			
E-mail:			2410
Attachments			: : :: :::::::::::::::::::::::::::::::
Replacing an app	any of the following changes from the cuproved waiver with this waiver. ers. ers. ever into two waivers.	urrent approved waiver. Check all boxes that apply.	
Adding or decrea	asing an individual cost limit pertainin asing limits to a service or a set of serv	ices, as specified in Appendix C.	
~~~~	duplicated count of participants (Factories ) decreasing, a limitation on the number	or C). of participants served at any point in time.	
waiver under 191	nges that could result in some participates.  15(c) or another Medicaid authority.  In reduced services that could result in reduced services.	ants losing eligibility or being transferred to another	
Specify the transition p		r r r	
			30%

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required. Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here. Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Iowa assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Iowa will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

#### Section 1: Assessment

Iowa proposes a multifaceted approach to assessment. This will include the completion of a Settings Analysis, which will be a high-level assessment of settings within the state to identify general categories (not specific providers or locations) that are likely to be in compliance; not in compliance; presumed to be non-HCBS; or those that are not yet, but could become compliant. Other avenues for assessment will include identifying HCBS settings during provider enrollment and reenrollment; evaluating settings through the existing HCBS quality assurance onsite review process and the provider self-assessment process; and monitoring of Iowa Participant Experience Survey (IPES) results for member experiences. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

All MCOs contracting with the State to provide HCBS are required to ensure non-institutional LTSS are provided in settings which comport with the CMS HCBS requirements defined at 42 CFR 441.301(c)(4) and 42 CFR 441.710(a). MCOs will be required to ensure compliance through the credentialing and monitoring of providers and service authorization for waiver participants.

10/1/2014 - 10/31/2014: Settings Analysis - State identified HCBS settings as they potentially conform to HCBS characteristics and ability to comply in the future. General settings are classified into categories (Yes - settings fully compliant, Not Yet - settings that will comply with changes, Not Yet - setting is presumed non-HCBS but evidence may be presented for heighted scrutiny review, and No - settings do not comply) The Iowa HCBS Settings Analysis is being submitted as one component of the transition plan .

12/1/2014 - 12/31/2014: Provider Enrollment Processes - State will operationalize mechanisms to incorporate assessment of settings into existing processes for provider pre-enrollment screening by the Iowa Medicaid Enterprise (IME), provider credentialing by the managed care behavioral health organization (BHO), and HCBS provider certification by the HCBS Quality Oversight unit.

5/1/2015 - 12/31/2015: Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Member Addresses - State will use GIS to analyze locations of provider sites and member addresses to identify potential areas with high concentration of HCBS.

12/1/2014 - ongoing: Onsite assessment - The State will incorporate review of settings into the review tools used by the HCBS Quality Oversight Unit for on-site reviews. Settings will be assessed during recertification reviews, periodic reviews, focused reviews, and targeted reviews. State will identify providers with sites of service that have the characteristics of HCBS or the qualities of an institution.

10/1/2014 - ongoing: Enrolled HCBS providers self-assessment - The state will modify the Provider Quality Management Self-Assessment to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution. The annual self-assessment will be released to providers annually on October 1 and due to IME annually on December 1, with results compiled by February 28. The State will release the "lowa Exploratory Questions for Assessment of HCBS Settings" document to assist providers in identifying the expected characteristics of HCBS.

8/1/2014 - ongoing: Other projects collecting HCBS setting data - State provider association will provide information and

input from residential providers to the state.

12/1/2014 - ongoing: Iowa Participant Experience Survey (IPES) - State will continue to monitor IPES results to flag member experience that is not consistent with assuring control over choices and community access. 5/1/2015 - By 3/17/2019: Onsite Assessment Results Report - State compiles and analyzes findings of onsite assessments annually by July 31, with the final report completed by 3/17/19. Findings will be presented to Iowa DHS leadership and stakeholders.

#### Section 2: Remediation Strategies

Iowa proposes a remediation process that will capitalize on existing HCBS quality assurance processes including provider identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. Iowa will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings timely may be subject to sanctions ranging from probation to disensolment.

6/1/2014 - 7/31/2016: Informational Letters - State will draft and finalize informational letters describing proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. BHO and MCO will provide the same information to provider network.

12/1/2014 - 7/31/2015: lowa Administrative Code - State will revise administrative rules chapters 441-77, 78, 79, and 83, to reflect federal regulations on HCBS settings. Rules will define HCBS setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come into compliance. Rules will clarify expectations of member control of their environment and access to community. BHO will develop the same standards for provider network.

8/1/2015 - 12/31/2015: Provider Manual Revisions - State will revise HCBS provider manual Chapter 16K to incorporate regulatory requirements for HCBS and qualities of an HCBS setting. BHO will incorporate the same information into relevant provider network manuals.

12/1/2014 - ongoing: Incorporate Education and HCBS Compliance Understanding into Provider Enrollment - IME Provider Services Unit Pre-Enrollment Screening process will make adjustments to ensure that HCBS settings are evaluated when appropriate. When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements. 12/1/2014 - ongoing: Provider Assessment Findings - State will present each provider with the results of the assessment of their organizational HCBS settings as findings occur throughout the assessment process.

12/1/2014 - 3/16/2019: Provider Individual Remediation - HCBS providers will submit a corrective action plan (CAP) for any settings that require remediation. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The state will accept the CAP or may ask for changes to the CAP. The state may preset remediation requirements for each organization's HCBS settings. Providers will be required to submit periodic status updates on remediation progress. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis. Locations presumed to be non-HCBS but which are found to have the qualities of HCBS will be submitted to CMS for heightened scrutiny review.

12/1/2014 - 3/16/2019: Data Collection - State, BHO, and MCO will collect data from reviews, technical assistance, updates, etc. to track status of remediation efforts. Data will be reported on a regular basis or ad hoc to DHS management and CMS.

12/1/2014 - 3/1/2019: Onsite Compliance Reviews - State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule.

12/1/2014 - 3/16/2019: Provider Sanctions and Disenrollments - State will disenroll and/or sanction providers that have failed to meet remediation standards. State will disenroll and/or sanction providers that have failed to cooperate with the HCBS Settings Transition.

12/1/2014 - 3/16/2019: Member Transitions to Compliant Settings - If relocation of members is necessary, the state will work with case managers, service workers, and care coordinators to ensure that members are transitioned to settings meeting HCBS Setting requirements. Members will be given timely notice and due process, and will have a choice of alternative settings through a person centered planning process. Transition of members will be comprehensively tracked to ensure successful placement and continuity of service.

#### Section 3: Public Comment

Iowa proposes to collect public comments on the transition plan through a dedicated email address for submission of written comments, and through taking public comments directly by mail. Iowa has also previously held a comment period in November 2014 which included solicitation of comments through stakeholder forums. In addition to posting the transition plan and related materials on the Iowa Medicaid website, numerous stakeholders were contacted directly and

provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Brain Injury Alliance of Iowa, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, NAMI Iowa, ASK Resource Center, Area Agencies on Aging, County Case Management Services, and MHDS Regional Administrators.

3/9/2015 - 3/13/2015: Announcement of Public Comment Period - State released a White Paper, the Draft Transition Plan, and Draft Settings Analysis on the state website. Informational Letters were released and sent to all HCBS waiver providers, case managers and DHS service workers. Stakeholders (listed above) were contacted directly to inform them of the public comment period. A dedicated email address (HCBSsettings@dhs.state.ia.us) was established to receive public comments. Tribal notices were sent. Notices were filed in newspapers. Printed versions were made available in DHS local offices statewide, along with instructions on submitting comments via mail.

3/16/2015 - 4/15/2015: Public Comment Period for Proposed Transition Plan - State will share transition plan with the public in electronic and non-electronic formats, collect comments, develop state responses to public comments, and incorporate appropriate suggestions into transition plan. The Response to Public Comments document will be posted to the DHS website and a summary provided to CMS. Previous comment periods were held in May 2014 and November 2014 which included stakeholder forums.

4/15/2015 - 3/16/2019: Public Comment Retention - State will safely store public comments and state responses for CMS and public consumption.

4/15/2015 - 3/16/2019: Posting of Transition Plan Iterations - State will post each approved iteration of the transition plan to its website.

7/1/2015 - By 3/17/2019: Assessment Findings Report - State shares the findings of the onsite assessment annually by July 31.

Iowa HCBS Settings Analysis - This Settings Analysis is general in nature and does not imply that any specific provider or location is noncompliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the transition plan, including but not limited to onsite reviews, provider annual self-assessments, IPES data, provider surveys, and GIS analysis.

Category: YES - Settings presumed fully compliant with HCBS characteristics

-- Member owns the housing, or leases housing which is not provider owned or controlled.

Category: NOT YET - Settings may be compliant, or with changes will comply with HCBS characteristics

- --Residential Care Facilities (RCFs) of any size
- -- Apartment complexes where the majority of residents receive HCBS
- --Provider owned or controlled housing of any size
- -- Assisted Living Facilities
- --Services provided in a staff member's home (except Respite)

Category: NOT YET - Setting is presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review

- -- Located in a building that also provides inpatient institutional treatment
- --Any setting on the grounds of or adjacent to a public institution
- --Settings that isolate participants from the broader community

Category: NO – Settings do not comply with HCBS characteristics

- --Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite)
- -- Nursing Facilities/Skilled Nursing Facilities
- --Hospitals
- --Institutions for Mental Disease (IMD)

#### Process:

Public comment was taken from March 16, 2015 through April 15, 2015. The transition plan was posted on the IME website at: https://dhs.iowa.gov/ime/about/initiatives/HCBS/TransitionPlans. The transition plan has been available at that location since March 12, 2015. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice was sent to the newspapers on March 9, 2015. The transition plan was available for non-electronic viewing in any of the 99 DHS office across the state for persons who may not have internet access. Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The address was provided for written comments to be submitted to the IME by mail or by delivering them directly to the IME office. Notice was also sent to the federally-recognized tribes on March 9, 2015.

### Summary of Comments:

Comments that resulted in changes to the transition plan:

There were no comments received that resulted in changes to the transition plan.

Comments for which the State declined to make changes to the transition plan or settings analysis document: There were numerous comments submitted which did not ask for changes to the transition plan, but rather were seeking clarification or interpretation of the federal regulation or posed operational questions about how the state would carry out activities in the transition plan.

Four commenters suggested that various aspects of the transition plan need to be updated to reflect the role that the Managed Care Organizations (MCOs) will have related to the Iowa High Quality Health Care Initiative. The state declined to makes changes based on the comment and explained in the response that Iowa plans to submit separate waiver amendments to make changes related to that effort in the near future, and that there will be another public comment period related to those amendments at that time.

Two commenters expressed concern about engaging consumers, families and advocates in the transition plan. The state declined to make changes based on the comment and explained the various ways that input from consumers and advocates has been sought in the development of the plan and expressed that consumer and advocate involvement will continue throughout implementation.

One commenter asked that the role of the state's Mental Health and Disability Services (MHDS) Regions be included in the plan. The state declined to make this change, explaining that the MHDS Regions are already listed as stakeholders in the plan.

One commenter asked that the plan be changed to eliminate the distinction between provider owned and controlled housing, as the commenter believed this had been eliminated from the regulation. The state declined to make this change and explained in the response that the federal regulation does still set out additional requirements for provider owned and controlled settings.

One commenter suggested that the "players" column which existed in an early draft of the transition plan, but was later removed should be added back into the plan. The state declined to make this change and explained in the response that the responsibility for completion of the activities listed in the transition plan lies with the IME, and other stakeholders are already noted in the description column for each item or in the explanatory narrative at the top of each section.

One commenter expressed that activities within the transition plan should not have end dates listed as "ongoing". The state declined to make this change and explained in the response that our approach utilizes an ongoing process of discovery, remediation, and improvement. As such, we are not performing a one-time statewide assessment that will result in a point-in-time list of settings that are compliant or non-compliant. Rather, our process will be a continuous cycle in which all settings will be assessed and remediated by the March 17, 2019 deadline, and our quality assurance processes will continue even after the transition deadline to assure that providers who were in compliance will continue to meet the requirements on an ongoing basis.

One commenter suggested that the actions or omissions that would trigger the requirement of a corrective action plan (CAP) should be listed in the transition plan. The state declined to make this change, explaining that any finding of noncompliance will trigger a CAP.

One commenter suggested that in regard to provider remediation, rather than the State allowing "reasonable time frames" for large infrastructure changes, the State should impose specific timeframes and deadlines. The state declined to make a change because we believe the commenter misunderstood the intent of the item. Our response to the comment explained that the timeframes that will be set out in any given CAP will be specific deadlines for that provider and location. The "reasonable timeframes" language needs to be read in the context of the previous sentence in the plan which indicates that in reviewing a CAP, the state will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question.

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The original document is too big. Please see the HCBS Statewide Transition Plan approved on August 9, 2016 on this link:

https://dhs.iowa.gov/sites/default/files/Approved Initial STP Submitted.pdf

# Appendix A: Waiver Administration and Operation

	i <b>te Li</b> lect o	ne of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver ne):
gerra y Agus r	Tbe	e waiver is operated by the State Medicaid agency.
	Spe one	cify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select):
		The Medical Assistance Unit.
		Specify the unit name:
		(Do not complete item A-2)
	error Tages	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.
		Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
		(Complete item A-2-a).
ê	The	e waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.
	Spe	cify the division/unit name:
Annend	adn inte poli	ccordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the ninistration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The ragency agreement or memorandum of understanding that sets forth the authority and arrangements for this cy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).  : Waiver Administration and Operation
exposite biological desirements and the second		
2. Ov	ersig	nt of Performance.
	th th N o in A	Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by the division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver peration, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:  Les indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.
	***************************************	
	N (I tl) o	Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver perational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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# Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (select one):
  - Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6.:

Iowa HealthLink-contracted MCOs will generally be responsible for delivering covered Iowa Medicaid benefits, including HCBS waiver programs, in a highly coordinated manner. Specific functions include; but are not limited to:

- Developing policies and procedures for ongoing identification of members who may be eligible for waiver services;
- Conducting comprehensive needs assessments, developing service plans, coordinating care, and authorizing and nitiating waiver services for all members;
- Conducting level of care reassessments with IME retaining final review and approval authority for any reassessments which indicate a change in the level of care;
- Delivering community-based case management services and monitoring receipt of services;
- Contracting with an entity or entities for financial management services to assist members who elect self-direction (i.e., Iowa's "Consumer Choices Option");
- Maintaining a toll-free telephone hotline for all providers with questions, concerns, or complaints;
- Maintaining a toll-free telephone hotline for all members to address questions, concerns, or complaints;
- Operating a 24/7 toll-free Nurse Call Line which provides nurse triage telephone services for members to receive medical advice from trained medical professionals;
- Creating and distributing member and provider materials (handbooks, directory, forms, policies and procedures, notices, etc.);
- Operating an incident reporting and management system:
- Maintaining a utilization management program;
- Developing programs and participating in activities to enhance the general health and well-being of members; and
- Conducting provider services such as network contracting, credentialing, enrollment and disenrollment, training, and claims processing.

Those members who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through the fee-for-service delivery system. As such, the State will continue to contract with the following entities to perform certain waiver functions.

Member Services (Maximus) as part of a contract with IME to disseminate information to Medicaid beneficiaries and provide beneficiary support as part of their customer service contract. Additionally, the Member Services Unit provides clinical review in effort to identify beneficiary population risks such that additional education, program support, and policy revision can mitigate risks to the beneficiary when possible.

Medical Services (Telligen) as part of a contract with the IME conducts level of care evaluations and service plan development ad-hoc reviews to ensure that waiver requirements are met. In addition, the IME MSU conducts the necessary activities associated with prior authorization of waiver services, authorization of service plan changes and medical necessity reviews associated with Program Integrity and Provider Cost Audit activities.

Home and Community Based Quality Assurance (Telligen), as part of a contract with the IME, reviews provider compliance with State and federal requirements, monitors complaints, monitors critical incident reports and provides technical assistance to ensure that quality services are provided to all Medicaid members.

Program Integrity and Recovery Audit Coordinator (Optum) as part of a contract with the IME reviews provider records and claims for instances of Medicaid fraud, waste, and abuse. These components are evaluated and

analyzed at an individual and system level through fraud hotline referrals and algorithm development.

Provider Services (Maximus) as part of a contract with the IME coordinates provider recruitment and executes the Medicaid Provider Agreement. The Provider Services Unit conducts provider background checks as required, conducts annual provider trainings, supervises the provider assistance call center, and manages the help functions associated with the IME's Individualized Services Information System (ISIS).

Provider Cost Audit (Myers and Stouffer) as part of a contract with the IME determines service rates and payment amounts. The Provider Cost Audit Unit performs financial reviews of projected rates, reconciled cost reports, and performs onsite fiscal reviews of targeted provider groups.

Revenue Collections Unit (HMS), as part of a contract with the IME, performs recovery of identified overpayments related to program integrity efforts, cost report reconciliations, third-party liability, and trusts.

Pharmacy (Gould Health Systems), as part of the contract with IME, this unit oversees the operation of the Preferred Drug List (PDL) and Prior Authorization (PA) for prescription drugs. The development and updating of the PDL allows the Medicaid program to optimize the funds spent for prescription drugs. The Pharmacy Medical group performs drug Prior Authorization with medical professionals who evaluate each request for the use of a number of drugs.

Point-of-Sale (POS) (Gould Health Systems), as part of the contract with the IME, this is the pharmacy point of sale system. It is a real-time system for pharmacies to submit prescription drug claims for Iowa Medicaid beneficiaries and receive a timely determination regarding payment.

All contracted entities, including Iowa Medicaid department staff, conduct training and technical assistance concerning their particular area of expertise concerning waiver requirements. Please note that ultimately it is the Medicaid agency that has overall responsibility for all of the functions while some of the functions are performed by contracting agencies. In regards to training, technical assistance, recruitment and disseminating information, this is done by both the Medicaid agency and contracted agencies throughout regular day-to-day business.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

## Appendix A: Waiver Administration and Operation

	of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver ional and administrative functions and, if so, specify the type of entity (Select One):		
8	ot applicable		
79.	pplicable - Local/regional non-state agencies perform waiver operational and administrative functions.  Check each that applies:  Local/Regional non-state public agencies perform waiver operational and administrative functions at the	ne	
	local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agence that is available through the Medicaid agency.  Specify the nature of these agencies and complete items A-5 and A-6:	responsibilities and performance requirements for these agencie acy.	
	Local/Regional non-governmental non-state entities conduct waiver operational and administrative		
	functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The <b>contract</b> (s) under which private entities conduct waiver operational functions are available to CMS upon request	;	

Specify the nature of these entities and complete items A-5 and A-6:

through the Medicaid agency or the operating agency (if applicable).

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# Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

IME Medical Policy Staff, through DHS, is responsible for oversight of the contracted entities. The DHS IME is the State Agency responsible for conducting the operational and administrative functions of the waiver.

# Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

IME is an endeavor that unites State Staff and "Best of Breed" contractors into a performance-based model for the administration of the Iowa Medicaid program. The IME is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program. Housed in a single building, the IME has contract staff who participates in the following activities: provider services, member services, provider audit and rate setting, processing payments and claims, medical services, pharmacy, program integrity, and revenue collections. All contracts are selected through a competitive request for proposal (RFP) process. Contract RFPs are issued every five years.

All contracted entities are assigned a State-employed contract manager, are assessed through their performance-based contracts, and are required to present their performance on contract standards at a monthly meeting to the Medicaid Policy Staff. Monthly meetings are designed to facilitate communication among the various business units within the IME to ensure coordination of operations and performance outcomes. Further, non-MCO contracted entities and Medicaid Policy staff are located at the same site, which limits the barriers of routine management and oversight. In addition, all contracted agencies are required to complete a comprehensive quarterly report on their performance to include programmatic and quality measures designed to measure the contract activities as well as trends identified within Medicaid programs and populations.

The State has established a MCO Oversight and Supports Bureau within IME to provide comprehensive program oversight and compliance. Specifically, the Bureau Chief, reporting directly to the Medicaid Director, is responsible for directing the activities of bureau staff. Each MCO account manager will oversee contract compliance for one designated MCO. The MCO account managers will serve as liaisons between the MCOs and the State, and will be the point of contact coordinating communications and connecting subject matter experts. The new Bureau will work directly with the IME Program Integrity Unit, which oversees compliance of all IME providers, including the MCOs.

# Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	Z.	2/4/4/4/2 	<b>.</b>
Waiver enrollment managed against approved limits	Z.		Z.
	1		

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Waiver expenditures managed against approved levels	₹.	ANDOL	V
Level of care evaluation	V	10 man	¥
Review of Participant service plans	Ž.	V 200.	Ž.
Prior authorization of waiver services	¥.		Ž
Utilization management	X.	V V 2011.	Ž:
Qualified provider enrollment	**************************************	# variable	*****
Execution of Medicaid provider agreements	×.	:-/\dots	Z
Establishment of a statewide rate methodology	V	vaccas:	V
Rules, policies, procedures and information development governing the waiver program	<u></u>		
Quality assurance and quality improvement activities	Ž.	est discours	

# Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

### a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

#### i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

AA-1: IME shall measure the number and percent of required MCO HCBS PM quarterly reports that are submitted timely. Numerator = # of HCBS PM quarterly reports submitted timely; Denominator = # of MCO HCBS PM quarterly reports due in a calendar quarter.

**Data Source** (Select one): **Other** If 'Other' is selected, specify:

MCO performance monitoring

Responsible Party for data collection/generation (check each that applies):	Frequency o collection/ge (check each t	neration	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly		₹ 100% Review
Operating Agency	✓ Monthl	V	Less than 100% Review
Sub-State Entity	Quarte	rly	Representative Sample Confidence Interval =
Other Specify: MCO	Annual	У	Stratified  Describe Group:
	Continu Ongoin	ously and	Other Specify:
	Other Specify:		N P
Data Aggregation and Anal Responsible Party for data and analysis (check each the	aggregation		f data aggregation and ck each that applies):
State Medicaid Agenc	<b>Y</b> 7	Weekly	<del>оду су пред мерри Арбилин в СССС</del> В ССССС СССС СССС СССС СССС ССС
Operating Agency		Month)	A 1
Sub-State Entity		Quartei	rly
Other Specify:		Annual	hy

Performance Measure:

AA-2: The IME shall measure the number and percent of months in a calendar quarter that each MCO reported all HCBS PM data measures. Numerator = # of months each

Other Specify:

Continuously and Ongoing

Data Source (Select one):

Responsible Party for

If 'Other' is selected, specify: MCO perforance monitoring

Other

MCO entered all required HCBS PM data; Denominator = # of reportable HCBS PM months in a calendar quarter.

Sampling Approach(check

Frequency of data

data collection/generation (check each that applies):	collection/ge (check each t		each that applies):
State Medicaid Agency	Weekly		7 100% Review
Operating Agency	✓ Monthl		Less than 100% Review
Sub-State Entity	Quarter	ly	Representative Sample Confidence Interval =
Other Specify: MCO	Annual	<b>i</b> y	Stratified  Describe Group:
District the GEE HEARING AND RECOVERING THE COMMENT OF T	Continu	ously and	Other
	Ongoin	<u>g</u>	Specify:
	Other Specify:	^ ~	Antonomial decision and the state of the sta
Data Aggregation and Anal Responsible Party for data and analysis (check each the	aggregation at applies):		f data aggregation and ik each that applies):
State Medicaid Agenc	<u>y</u>		
Operating Agency		Monthly	,
Sub-State Entity		☑ Quarter	ły
Other Specify:	¢.	Annuall	<b>y</b>
and a second control of the second of the se	an an Anna an	Continu	ously and Ongoing
A A A A A A A A A A A A A A A A A A A	W 101 . O L COMMINSON	Other	

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Through the Bureau of Managed Care each MCO is assigned state staff as the contract manager; and other state staff are assigned to aggregate and analyze MCO data. This staff oversees the quality and timeliness of monthly reporting requirements. Whenever data is late or missing the issues are immediately addressed by each MCO account manager to the respective MCO.

#### b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If the contract manager, or policy staff as a whole, discovers and documents a repeated deficiency in performance of the MCO, a plan for improved performance is developed. In addition, repeated deficiencies in contractual performance may result in a withholding of payment compensation.

General methods for problem correction include revisions to state contract terms based on lessons learned.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	☑ Monthly
Sub-State Entity	Quarterly
Other Specify: Contracted Entity and MCOs	Annually
	Continuously and Ongoing
Author And Control Con	Other Specify:

#### c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

 The first of the f
No
Yes
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing
identified strategies, and the parties responsible for its operation.
A

# Appendix B: Participant Access and Eligibility

# B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

				Maximum Age	
Target Group	Included	Target SubGroup	Minimum Age	Maximum Age Limit	No Maximum Ag Limit
Aged or Disab	oled, or Both - G	eneral		21 44	mathewater, et al. a.
	2000000 20000000 200000000000000000000	Aged	a different services		
	2	Disabled (Physical)	18	64	
	**************************************	Disabled (Other)			
Aged or Disab	led, or Both - S	pecific Recognized Subgroups			
	50 (1975) 1 10 (1975) 1 10 (1975) 1	Brain Injury			ang an ye
	Antonio A.	EUV/AIDS			200 (AMA) A 1
	:	Medically Fragile			9-9/A
	Car Andre	Technology Dependent			2
Intellectual Di	sability or Deve	elopmental Disability, or Both	THE RESIDENCE OF THE PARTY OF T	-	L
	fish o Anny.	Autism	1		
	Manada a programpa	Developmental Disability	Control Prince		
		Intellectual Disability			79600
Mental Illness		**************************************		Million de de mandre de marier de la papera d	
MODELLA CONTROL DE LA PRESENCIA DE CONTROL DE VINCENZA DE PRESENCIA DE CONTROL DE CONTRO	community (	Mental Illness			
	10 mars	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The member must be blind or disabled as determined by the receipt of social security disability benefits or through a disability determination made by the department. Disability determinations are made in accordance to supplemental security income guidelines under Title XVI of the Social Security Act or disability guidelines for the Medicaid employed people with disabilities coverage. The approved member must be ineligible for HCBS for individuals with an Intellectual Disability as diagnosed in the DSM-V.

- c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):
  - Not applicable. There is no maximum age limit
  - The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Upon reaching the age of 65, a PD member, either FFS or MCO, may be eligible to receive services through another HCBS waiver (e.g., the Elderly waiver); or State Plan services (e.g. PACE) that may meet the member's needs.

#### FFS Members

The income maintenance worker receives notification from an ISIS milestone when a member is turning 65. An ISIS workflow is started 30 days before the member's 65th birthday for both FPS and MCO members. The income maintenance worker will close the PD waiver case and send the member a letter informing them they are no longer eligible for the PD Waiver but they may be eligible for another waiver. The letter offers the member the option to complete the HCBS assessment form and return for an eligibility determination.

The assigned DHS case manager will coordinate transition services for the PD member. An ISIS milestone is generated 30 days before the 65th birthday to notify the member that he/she will lose PD age eligibility upon reaching the age of 65 and the contact information for additional information regarding service choices.

If the member chooses to apply for another waiver, the application may be submitted no earlier than 60 days prior to the 65th birthday.

A new level of care assessment is not required if current within 365 days.

#### MCO Members

As in the FFS process, the income maintenance worker receives notification from an ISIS milestone when a MCO member is turning 65. The income maintenance worker will close the PD waiver case and send the member a letter informing them they are no longer eligible for the PD Waiver but they may be eligible for another waiver. The letter offers the member the option to complete the HCBS assessment form and return for an eligibility determination.

The assigned MCO care coordinator will coordinate transition services for the MCO PD member.

If the member chooses to apply for another waiver, the application may be submitted no earlier than 60 days prior to the 65th birthday.

IME provides daily and monthly data transfers that include changes in individual HCBS member changes or key ages that can affect a member's eligibility. Also, each MCO establishes its own processes to ensure a successful transition to other services from the PD Waiver because of the age criteria.

A new level of care assessment is not required if current within 365 days.

# Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

- a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (select one). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
  - No Cost Limit. The State does not apply an individual cost limit. Do not complete Item B-2-b or item B-2-c.
  - Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. Complete Items B-2-b and B-2-c.

The limit specified by the State is (select one)

, 	A level higher than 100% of the institutional average
	Specify the percentage
<u>.</u>	Other
	Specify:

Institutional Cost Limit. Pursuant to 42 CFR 44:301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services formisched to that individual would exceed 100% of the cost of the borne and community-based services from the theory of the factor of the few of care specified for the waiver.  Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of nome and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of warver participants. Complete hems B-2-b and B-2-c  The cost limit specified by the State is (select one):  The dollar amount:  Specify dollar amount:  Specify dollar amount:  Specify the formula:  May be adjusted each year that the waiver is in effect by applying the following formula:  May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify percent:  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  h. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:		in the second se
qualified individual when the State reasonably expects that the cost of home and community-based services firmished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c  The cost limit specified by the State is (select one):  The following dollar amount:  Specify dollar amount (select one)  Is adjusted each year that the waiver is in effect by applying the following formula:  Specify the formula:  May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify:  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and	42 e . 100 e .	otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.
The cost limit specified by the State is (select one):  The following dollar amount:  Specify dollar amount:  The dollar amount (select one)  Is adjusted each year that the waiver is in effect by applying the following formula:  Specify the formula:  May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify percent  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and	jena vert	qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of
The following dollar amount:    Specify dollar amount (select one)		
The following dollar amount:    Specify dollar amount (select one)		
Specify dollar amount:  The dollar amount (select one)  Is adjusted each year that the waiver is in effect by applying the following formula:  Specify the formula:  May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify:  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		The cost limit specified by the State is (select one):
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Specify the formula:  Specify the formula:  May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify percent:  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		Specify dollar amount:
Specify the formula:  May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify percent:  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		The dollar amount (select one)
May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.  The following percentage that is less than 100% of the institutional average:  Specify percent:  Other:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		Is adjusted each year that the waiver is in effect by applying the following formula:
Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		Specify the formula:
Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		
Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		h _b c.
Specify percent:  Specify:  Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		
Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		The following percentage that is less than 100% of the institutional average:
Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		Specify percent:
Appendix B: Participant Access and Eligibility  B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		Other:
B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		Specify:
B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		
B-2: Individual Cost Limit (2 of 2)  Answers provided in Appendix B-2-a indicate that you do not need to complete this section.  b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		
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b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and		B-2: Individual Cost Limit (2 of 2)
specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and	Answers p	rovided in Appendix B-2-a indicate that you do not need to complete this section.
	spe	cify the procedures that are followed to determine in advance of waiver entrance that the individual's health and
V.O. I	eggerra ananyyen ra	

c.	Participant Safeguards. When the State specifies an individual cost limit in participant's condition or circumstances post-entrance to the waiver that require amount that exceeds the cost limit in order to assure the participant's health an following safeguards to avoid an adverse impact on the participant (check each). The participant is referred to another waiver that can accommodate.  Additional services in excess of the individual cost limit may be authorized.	res the provision of services in an d welfare, the State has established the h that applies): the individual's needs.					
	Specify the procedures for authorizing additional services, including the	amount that may be authorized:					
		<u>^</u>					
	Other safeguard(s)	· ·					
	Specify:						
		<u> </u>					
Appe	ndix B: Participant Access and Eligibility						
	B-3: Number of Individuals Served (1 of 4)						
а.	Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:						
	Table: B-3-a Waiver Year	Unduplicated Number of Participants					
	Year 1	1492					
	Year 2	1522					
	Year 3	1553					
	Year 4	1584					
	Year 5	1615					
	Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (select one):						
The State does not limit the number of participants that it serves at any point in time do waiver year.  The State limits the number of participants that it serves at any point in time during a very server at any point in time during a very server.							
							The limit that applies to each year of the waiver period is specified in the following table:
	Table: B-3-b						
	Waiver Year Maximum Number of Partic Served At Any Point During						
	Year 1 1161						
	Year 2	and the state of t					

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	1200
Year 3	1238
Year 4	1276
Year 5	1317

# Appendix B: Participant Access and Eligibility

# B-3: Number of Individuals Served (2 of 4)

- c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (select one):
  - Not applicable. The state does not reserve capacity.
  - The State reserves capacity for the following purpose(s).

# Appendix B: Participant Access and Eligibility

## B-3: Number of Individuals Served (3 of 4)

- d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (select one):
  - The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Approved, in-process, and waiting list figures can be found on the DHS website at: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Per 441 Iowa Administrative Code 83.102(5)(b), PD waiver slots are available on a first-come, first-served basis. If no slot is available, applicants are entered onto a waiting list according to the following:

"(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date

the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list."

The PD waiver does not have an emergency or reserve capacity list.

Appendix B: Participant Access and Eligibility
B-3: Number of Individuals Served - Attachment #1 (4 of 4)
Answers provided in Appendix B-3-d indicate that you do not need to complete this section.
Appendix B: Participant Access and Eligibility
B-4: Eligibility Groups Served in the Waiver
a
1. State Classification. The State is a (select one):
§1634 State
SSI Criteria State
209(b) State
2. Miller Trust State.
Indicate whether the State is a Miller Trust State (select one):
Yes
<ul> <li>b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. Check all that apply:</li> <li>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</li> </ul>
Low income families with children as provided in §1931 of the Act
SSI recipients
Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
Optional State supplement recipients
Optional categorically needy aged and/or disabled individuals who have income at:
Select one:
100% of the Federal poverty level (FPL)
% of FPL, which is lower than 100% of FPL.
Specify percentage:
Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in
§1902(a)(10)(A)(ii)(XIII)) of the Act)
Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as
provided in §1902(a)(10)(A)(ii)(XV) of the Act)
Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
Group as provided in grown and rolling the week

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134				
eligibility group as provided in §1902(e)(3) of the Act)  Medically needy in 209(b) States (42 CFR §435.330)				
Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)				
Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the				
State plan that may receive services under this waiver)				
Specify:				
Groups included under mandatory coverage of the aged blind and disability as listed in 42 CFR §435.122, 130 - 131, 133 - 135, 137 - 138, and optional groups listed in 42 CFR §435.210.				
Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed				
No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.				
Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.				
Select one and complete Appendix B-5.				
All individuals in the special home and community-based waiver group under 42 CFR §435.217  Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217				
Check each that applies:				
A special income level equal to:				
Select one:				
Select one:  300% of the SSI Federal Benefit Rate (FBR)				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the				
300% of the SSI Federal Benefit Rate (FBR) A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)  Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)  Medically needy without spend down in 209(b) States (42 CFR §435.330)				
300% of the SSI Federal Benefit Rate (FBR) A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage: A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)  Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)				
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A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)  Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)  Medically needy without spend down in 209(b) States (42 CFR §435.330)  Aged and disabled individuals who have income at:  Select one:				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)  Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)  Medically needy without spend down in 209(b) States (42 CFR §435.330)  Aged and disabled individuals who have income at:  Select one:  100% of FPL  % of FPL, which is lower than 100%.				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)  Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)  Medically needy without spend down in 209(b) States (42 CFR §435.330)  Aged and disabled individuals who have income at:  Select one:  100% of FPL  % of FPL, which is lower than 100%.  Specify percentage amount:				
300% of the SSI Federal Benefit Rate (FBR)  A percentage of FBR, which is lower than 300% (42 CFR §435.236)  Specify percentage:  A dollar amount which is lower than 300%.  Specify dollar amount:  Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)  Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)  Medically needy without spend down in 209(b) States (42 CFR §435.330)  Aged and disabled individuals who have income at:  Select one:  100% of FPL  % of FPL, which is lower than 100%.				

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Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income (1 of 7)
In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.
a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:
Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.
Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals
with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.
Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).
Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.
In the case of a participant with a community spouse, the State elects to (select one):
Use spousal post-eligibility rules under §1924 of the Act. (Complete Item B-5-b (SSI State) and Item B-5-d)
Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income (2 of 7)
Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.
b. Regular Post-Eligibility Treatment of Income: SSI State.
The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:
i. Allowance for the needs of the waiver participant (select one):
The following standard included under the State plan

https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.jsp

Select one:

SSI standard

	Marin .	Optional State supplement standard			
		Medically needy income standard			
	A	The special income level for institutionalized persons			
		(select one):			
		300% of the SSI Federal Benefit Rate (FBR)			
		A percentage of the FBR, which is less than 300%			
		Specify the percentage:			
		A dollar amount which is less than 300%.			
		Specify dollar amount:			
		A percentage of the Federal poverty level			
		Specify percentage:			
		Other standard included under the State Plan			
		Specify:			
			n.		
-7					
- North	The	following dollar amount			
	Spe	cify dollar amount: If this amount changes, this item will be revised.			
	The	following formula is used to determine the needs allowance:			
	Spe	cify:			
	part	following formula is used to determine the needs allowance: 300% of the SSI benefit and for icipants who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if ordered) to pay for administrative costs.			
	DHS determines patient liability. For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.				
	whi capi liab For	capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component ch is a blend of institutional services and home and community based services (HCBS). When tation rates were developed, the LTSS component was calculated with consideration given to patient ility as a possible source of funds used to pay a portion of the services provided through the waiver, both the institutional and HCBS component of the rate, the average patient liability was subtracted, refore, the MCOs are paid net of the average patient liability.			
San S	Oth	er			
	Spe	eify:			
	Г		P. Carrie		
		<u>~</u>			
Alio	wan	ce for the spouse only (select one):	_		
	Not	Applicable	-		
	The	estate provides an allowance for a spouse who does not meet the definition of a community use in §1924 of the Act. Describe the circumstances under which this allowance is provided:			

ii.

		Specify:
		Specify the amount of the allowance (select one):
		SSI standard
		Optional State supplement standard
		Medically needy income standard  The following dollar amount:
		ine following donar amount.
		Specify dollar amount: If this amount changes, this item will be revised.
		The amount is determined using the following formula:
		Specify:
	4 31	
111.	Allo	owance for the family (select one):
	ata.	Not Applicable (see instructions)
	: 6	AFDC need standard
		Medically needy income standard
	-	The following dollar amount:
		Specify dollar amount: The amount specified cannot exceed the higher of the need standard
		for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
	11.50 11.50	The amount is determined using the following formula:
		Specify:
		Other
		Specify:
		, A
in.	4 m	ounts for incurred medical or remedial care expenses not subject to payment by a third party,
17.		cified in 42 §CFR 435.726:
		<ul> <li>a. Health insurance premiums, deductibles and co-insurance charges</li> <li>b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of thes</li> </ul>
		expenses.
	Sele	ect one:
	:_:	Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
		The State does not establish reasonable limits.

The State establishes the following reasonable limits
Specify:
Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income (3 of 7)
Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.
c. Regular Post-Eligibility Treatment of Income: 209(B) State.
Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.
Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income (4 of 7)
Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.
d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules
The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).
i. Allowance for the personal needs of the waiver participant
(select one):
SSI standard
Optional State supplement standard  Medically needy income standard
The special income level for institutionalized persons
A percentage of the Federal poverty level
Specify percentage:
The following dollar amount:
Specify dollar amount: If this amount changes, this item will be revised
The following formula is used to determine the needs allowance:
Specify formula:
Other
Specify:

300% of the SSI benefit and for members who have a medical assistance income trust (Miller Trust) an additional \$10 (or higher if court ordered) to pay for the administration fees.

DHS determines patient liability. For managed care enrollees with a patient liability, DHS will communicate to the MCO the amount of each member's liability. Members will be responsible for remitting their patient liability to their waiver providers. The MCO reduces its payment for a member's waiver services up to the amount of the patient liability.

The capitation rates calculated for MCOs includes a long-term services and supports (LTSS) component which is a blend of institutional services and home and community based services (HCBS). When capitation rates were developed, the LTSS component was calculated with consideration given to patient liability as a possible source of funds used to pay a portion of the services provided through the waiver. For both the institutional and HCBS component of the rate, the average patient liability was subtracted. Therefore, the MCOs are paid net of the average patient liability.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

 Allowance is the same Allowance is different.				
Explanation of difference:				
	, F.			
	k Royal			

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:
  - a. Health insurance premiums, deductibles and co-insurance charges
  - b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

### Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

# Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

# Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:
  - i. Minimum number of services.

The minimum number of waiver services	(one or	more) that	an individual	must require in	order to be
determined to need waiver services is: 1					

- ii. Frequency of services. The State requires (select one):
  - The provision of waiver services at least monthly
  - Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

HCBS waiver services must be accessed at least once every calendar quarter by the member both FFS and MCO members.

- b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):
  - Directly by the Medicaid agency
  - By the operating agency specified in Appendix A
  - By an entity under contract with the Medicaid agency.

Specify the entity:

The IME MSU is responsible for determining the initial level of care evaluation for waiver enrollment with the input of the case manager, health home coordinator, community-based case manager, medical professional, and other appropriate professionals. For fee-for-service members, the reevaluation is also conducted by the IME MSU. MCOs are responsible for reevaluations of their members. The IME MSU reviews and approves all reevaluations that indicate a change in the member's level of care. MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. Upon identification the MCO completes the initial level of care assessment with the IME MSU maintaining final review and approval authority.

(7)	Other Specify:	
		jerit.
		.No

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Medical professionals (i.e., licensed physician, physician assistant or advanced registered nurse practitioner) perform the initial evaluation/complete the assessment tool. The IME requires that professionals completing the level of care determination are licensed RNs. If the RN is unable to approve level of care, then the Physician Assistant or MD make the final level of care determination.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

IME Medical Services uses the following assessments to evaluate and reevaluate applicants and members: Physical Disability (PD)

Ages 18 - 20: interRAl - Pediatric Home Care (PEDS-HC)

Ages 21+: interRAI - Home Care (HC)

PD with Habilitation

Age 18: inter-RAI Child and Youth Mental Health (ChYMH) Ages 19 – 64: interRAI - Community Mental Health (CMH)

The interRAI Home Care Assessment System (HC) has been designed to be a user-friendly, reliable, person-centered assessment system that informs and guides comprehensive care and service planning in community-based settings around the world. It focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences, and facilitates referrals when appropriate. When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services. The interRAI HC can be used to assess persons with chronic needs for care as well as those with post-acute care needs (for example, after hospitalization or in a hospital-at-home situation). Areas of review include: (1) cognitive; (2) mood and behavior patterns; (3) physical functioning — mobility; (4) skin condition; (5) pulmonary status; (6) continence; (7) dressing and personal hygiene — ADLS; (8) physical functioning — eating; (9) medications; (10) communication/hearing/vision patterns; and (11) prior living - psychosocial.

- e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):
  - The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
  - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The interRAI HC Assessment Form is a Minimum Data Set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI HC items

also identify persons who could benefit from further evaluation of specific problems of risks for functional decline. These are triggers that link the interRAI HC to a Clinical Assessment Protocol. The CAPS contain general guidelines for further assessment.

The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care. These include:

- *Scales for ADLs, cognition, communication, pain, depression, and medical instability
- *Clinical Assessment Protocols that contain strategies to address problem conditions as triggered by one or more HC item responses
- *Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems)
- *A quality monitoring system (Home Care Quality Indicators, or HCQIs)
- *A case-mix system that creates distinct service-use intensity categories (RUG-III/HC)

IME Medical Services may request additional information from the service worker, case manager, health home coordinator, or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

It is the responsibility of the case manager, health home coordinator, or community-based case manager to assure the assessment is initiated as required to complete the initial level of care determination. For FFS members, the initial assessment is completed by the Core Standardized Assessment(CSA) contractor Telligen and sent to the case manager, or care coordinator, who uploads the assessment to the IME MSU. For MCO members, the MCO is responsible to ensure the CSA is completed, and then uploaded the assessment to the IME MCU. The IME MSU is responsible for determining the level of care based on the completed assessment tool and supporting documentation from medical professionals.

The Continued Stay Review (CSR) is completed annually and when the a case manager or health home coordinator becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. The CSR process uses the same assessment tool as is used with the initial level of care determination. It is the responsibility of the case manager or health home coordinator to assure the assessment is initiated as required to complete the CSR. For fee-for-service members, the ISIS system sends out a milestone 60 days prior to the CSR date to remind case managers and health home coordinators of the upcoming annual LOC process. The FFS CSA contractor completes these assessment, and the IME MSU conduct LOC redeterminations.

MCOs are responsible for conducting level of care reevaluations for members, using DHS designated tools, at least annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect level of care eligibility. Additionally, any member or provider can request a reevaluation at any time. Once the reevaluation is complete, the MCO submits the level of care or functional eligibility information to the IME MSU. The State retains authority for determining Medicaid categorical, financial, level of care or needs-based eligibility and enrolling members into a Medicaid eligibility category. MCOs track and report level of care and needs-based eligibility reevaluation data, including, but not limited to, reevaluation completion date. MCOs are required to notify DHS of any change in level of care and DHS retains final level of care determination authority. As the State is a neutral third party with final approval authority, there is no conflict of interest.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

MCOs are required to employ the same professionals. Further, MCOs are contractually required to ensure on an

ongoing basis that all staff has the appropriate credentials, education, experience and orientation to fulfill the requirements of their position. As applicable based on the scope of services provided under a subcontract, MCOs must ensure all subcontractor staff is trained as well. Staff training shall include, but is not limited to: (i) contract requirements and State and Federal requirements specific to job functions; (ii) training on the MCOs policies and procedures on advance directives; (iii) initial and ongoing training on identifying and handling quality of care concerns; (iv) cultural sensitivity training; (v) training on fraud and abuse and the False Claims Act; (vi) HIPAA training; (vii) clinical protocol training for all clinical staff, (viii) ongoing training, at least quarterly, regarding interpretation and application of utilization management guidelines for all utilization management staff; (ix) assessment processes, person-centered planning and population specific training relevant to the enrolled populations for all care managers; and (x) training and education to understand abuse, neglect, exploitation and prevention including the detection, mandatory reporting, investigation and remediation procedures and requirements. Policies and Procedures Manuals must also be provided to the MCO's entire staff and be incorporated into all training programs for staff responsible for providing services. Finally, MCOs must maintain documentation to confirm staff training, curriculum, schedules and attendance. DHS reserves the right to review training documentation and require the MCO to implement additional staff training. Reevaluation Schedule. Per 42 CFR \$441.303(c)(4), reevaluations of the level of care required by a participant are

₩.	conducted no less frequently than annually according to the following schedule (select one):				
	<u>_</u>	Every three months			
	, comp.,	Every six months			
	6	Every twelve months			
	ر سد الحريدة	Other schedule Specify the other schedule:	٠		
			A		
h.	_	alifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who pervaluations (select one):	form		
		The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.	n		
	()	The qualifications are different.			
		Specify the qualifications:			
			44		

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):

**FFS** 

The FFS CSA contactor is responsible for submitting timely level of care reevaluations of members. Reevaluations are considered timely if they are completed within twelve (12) months of the previous evaluation. Reevaluations of FFS members are tracked in the DHS Individualized Services Information System (ISIS). An ISIS milestone is sent out to the FFS CSA contractor 60 days before the reevaluation is due.

On a weekly basis, an ISIS CSR report is extracted to identify FFS overdue reevaluations. The list is sent to the management team for DHS Targeted Case Management for resolution. The DHS TCM submits a weekly status report to the designated HCBS program manager for monitoring with conferencing as needed.

A CSR or re-evaluation report is also available through ISIS to track overdue reevaluations and is monitored by Medical Services, the Bureau of Long Term Care (BLTC), and IME.

MCO

Reevaluations of MCO members are also tracked in the DHS Individualized Services Information System (ISIS) for IME oversight. However, MCOs are also responsible for recording timely completion of level of care reevaluations of members. One hundred percent (100%) of member level of care reevaluations must be completed within twelve (12) months of the previous evaluation. ISIS is queried weekly to monitor the status of MCO LOC determinations. This information is shared with MCO account mangers. DHS reserves the right to audit MCO application of level of care criteria to ensure accuracy and appropriateness.

MCOs are contractually required to develop and maintain their own electronic community-based case management systems that include functionality to ensure compliance with the State's 1915(c) HCBS waiver and law. This includes, but is not limited to, the ability to capture and track: (i) key dates and timeframes such as enrollment date, date of development of the care plan, date of care plan authorization, date of initial service delivery, date of level of care and needs reassessments and dates of care plan updates and the functionality to notify the community-based case manager or care coordinator of care plan, assessment and reassessment deadlines; (ii) the care plan; (iii) all referrals; (iv) level of care assessment and reassessments; (v) needs assessments and reassessments; (vi) service delivery against authorized services and providers; (vii) actions taken by the community-based case manager or care coordinator to address service gaps; and (viii) case notes.

Should MCO reevaluations not be completed in a timely manner, DHS may require corrective action(s) and implement intermediate sanctions in accordance with 42 CFR 438, Subpart I. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. The non-compliance corrective actions may be instituted in any sequence and include, but are not limited to, a written warning, formal corrective action plan, withholding of full or partial capitation payments, suspending auto-assignment, reassigning an MCO's membership and responsibilities, appointing temporary management of the MCO's plan, and contract termination. In the event of non-compliance with reevaluation timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluation and reevaluation level of care documents are faxed to the IME MSU regardless of delivery system (i.e., FFS members and MCO members) and placed in "OnBase." OnBase is the system that stores documents electronically and establishes workflow. In addition, the waiver member's case manager, health home coordinator, or community-based case manager is responsible for service coordination for each member. These providers maintain a working case file for each member and must maintain the records for a period of five years from the date of service. The case file includes all assessments, both initial and ongoing, completed during the time the member was receiving waiver services. MCOs also maintain electronic case management systems that are used to capture and track all evaluations and reevaluations.

# Appendix B: Evaluation/Reevaluation of Level of Care

# Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

### i. Sub-Assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

LC-a1: IME will measure the number and percent of approved LOC decisions. Numerator: # of completed LOC; Denominator: # of referrals for LOC.

**Data Source** (Select one): Other

If 'Other' is selected, specify:

FFS and MCO members will be pulled from ISIS for this measure. IME MSU completes all initial level of care determinations for both FFS and MCO

populations.	3	<u> </u>
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies).
✓ State Medicaid  Agency	Weekly	₹ 100% Review
Operating Agency	<b> W</b> onthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
♥ Other     Specify:     contracted entity	Annually	Stratified  Describe  Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):	
Operating Agency	Monthly	
Sub-State Entity	✓ Quarterly	
Other Specify:	Annually	
	Continuously and Ongoing	
	Other Specify:	

b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

LC-c1: The IME shall determine the number and percent of initial level of care decisions that were accurately determined by applying the approved LOC criterion using standard operating procedures. Numerator: # of of LOC decisions that were accurately determined by applying the correct criteria as defined in the waiver; Denominator: # of reviewed LOC determinations.

Data Source (Select one): Other

If 'Ot	her' is	sele	cted,	specify:
IME	MQ	JIDS	and	OnBase

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):	
State Medicaid Agency	Weekly	100% Review	
Operating Agency	✓ Monthly	✓ Less than 100% Review	
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%	
	Annually	Stratified  Describe  Group:	
	Continuously and Ongoing	Other Specify:	
	Other Specify:		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
<del></del>	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Data for completed LOC is collected quarterly through reports generated through ISIS, MQUIDS, and OnBase. This data is monitored for trends from an individual and systems perspective to determine in procedural standards.

Monthly a random sample of LOC decisions is selected from each reviewer. IQC activity is completed on the random sample. This level of scrutiny aids in early detection of variance from the stated LOC criteria.

### b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred, the unit undertakes additional training for staff.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
₹ State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	☑ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

#### c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

	to the first of the same and th
<b>@</b>	No
	Yes
	Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified
	strategies, and the parties responsible for its operation.
	· ·
	¥

# Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**FFS** 

DHS is dedicated to serving individuals in the communities of their choice within the resources available and to implementing the United States Supreme Court's mandate in Olmsted v. L.C. As such, services are provided in a manner that facilitates maximum community placement and participation for members that require LTSS.

In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, service plans must reflect the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports.

The person-centered process is holistic in addressing the full array of medical and non-medical services and supports to ensure the maximum degree of integration and the best possible health outcomes and member satisfaction. Moreover, members are given the necessary information and support to ensure their direction of the process to the maximum extent possible, and to empower them to make informed choices and decisions regarding the services and supports received.

During enrollment of fee-for-service members, ISIS requires that case managers (CM) and health home coordinators attest to having offered a choice between HCBS or institutional services. Choice is verified by: (1) marking the waiver box on the application; (2) sending a written request asking for waiver services; or (3) verbally confirming the member's choice with the income maintenance worker and the case manger or health home coordinator documents the conversation.

Further, there are waiver informational brochures available to share with memberss and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

MCO

MCO community case managers are required ensure that members are offered choice according to their respective MCO processes and forms, which are reviewed and approved by DHS.

As part of the 2017 EQR process, a focused study was conducted regarding Person Centered Care Planning processes of the MCOs. The EQR vendor conducted onsite visits to review MCO documentation of person centered care planning (including freedom of choice) for a sample of MCO members to verify that MCOs are maintaining records of such processes. The results of this study will be provided to the IME in Spring 2018. MCO account managers will then work with the MCOs to ensure that choice is documented as part of the overall process.

In addition, the IME Medical Services Unit (MSU)reviews the person centered service plan to determine if provider choice (including CCO) is offered.

The HCBS Unit, during the IPES member telephone surveys, asks members if they are offered choice of providers. The HCBS regional specialists (part of the HCBS QA Unit) as part of the IDT/CBCM Ride Along activity, identifies if provider choice is offered during the IDT meetings.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice forms for fee-for-service participants is documented in member service plans and in ISIS. MCOs are responsible for maintaining records that fully disclose the extent of services provided to members for a minimum of seven years, and must furnish such information to duly authorized and identified agents or

representatives of the state and federal governments.

#### MCO

The 2017 External Quality Review (EQR) process included a focused study on the MCOs Person Centered Care Planning processes. The EQR vendor requests documentation of person centered care planning (including freedom of choice) for a sample of MCO members to verify that MCOs are maintaining records of such processes. The results of this study will be provided to the IME in Spring 2018. MCO account managers will then work with the MCOs to ensure that choice is documented as part of the overall process.

# Appendix B: Participant Access and Eligibility

# B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

lowa DHS adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. DHS shall provide for communication with people with limited English proficiency, including current and prospective patients or clients, family members and members to ensure them an equal opportunity to benefit from services. DHS has developed policies and procedures to ensure meaningful access for people with limited English proficiency. This includes procedures to:

- Identify the points of contact where language assistance is needed.
- Identify translation and interpretation resources, including their location and their vailability.
- Arrange to have these resources available in timely manner.
- Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
- Determine effective means for notifying people with limited English proficiency of available translation services available at no cost.
- Train department staff on limited English proficiency requirements and ensure their ability to carry them out.
- Monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to services.

All applications and informational handouts are printed in Spanish. In addition, the contract with IME Member Services requires that a bilingual staff person be available to answer all telephone calls, emails and written inquires. They also work with interpreters if another spoken language is needed. All local DHS offices have access to a translator if a bilingual staff person is not available. DHS includes this policy as part of their Policy on Nondiscrimination that can be found in the DHS Title I General Departmental Procedures in the Department Employee Manual.

Locally, each county DHS office utilizes the resources that are available to them. For example, in larger metropolitan areas, local offices have staff that is fluent in Spanish, Bosnian, and Southeastern Asian languages. Some offices utilize translators from DHS Refugee Services. Other areas of the state have high Russian populations and access the translators in the area. All county offices have access to the Language Line service where they may place a telephone call and request a translator when one is not available at the local office. Medicaid members may call the IME Member Services unit with any questions relating to Medicaid, including waiver services. Member Services has translation capabilities similar to the local DHS offices and uses the Language Line to address any language when Member Services does not have an interpreter on staff.

MCOs must conform to DHS policies regarding meaningful access to the waiver by limited English proficient persons, and to deliver culturally competent services in accordance with 42 CFR 438.206.

- MCOs must provide language services at no cost to limited English proficiency members, and all written materials shall be provided in English and Spanish, as well as any additional prevalent languages identified by the State or through an analysis of member enrollment (i.e., any language spoken by at least five percent (5%) of the general population in the MCO's service

area).

- MCOs must provide oral interpretation services free of charge to each member (this applies to all non-English languages, and is not limited to prevalent languages), and MCOs must notify all members that oral interpretation and translated written information is available and how to access those services. Written materials must include taglines in prevalent languages regarding how to access materials in alternative languages.
- MCOs must ensure that service plans reflect cultural considerations of the member and that service plan development is

conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b).

- MCOs must operate member services helplines that are available to all callers, and an automated telephone menu options must be made available in English and Spanish.
- MCOs must maintain member websites and mobile applications available in English and Spanish that are accessible and functional via cell phone.

All MCO developed member communications, including substantive changes to previously approved communications, must be approved by DHS prior to use/distribution.

# Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service	
Supports for Participant Direction	Financial Management Services	
Supports for Participant Direction	Independent Support Broker	
Supports for Participant Direction	Individual Directed Goods and Services	
Supports for Participant Direction	Self Directed Personal Care	
Supports for Participant Direction	Self-directed Community Support and Employment	
Other Service	Consumer-Directed Attendant Care (Skilled)	
Other Service	Consumer-Directed Attendant Care (Unskilled)	
Other Service	Home and Vehicle Modification	
Other Service	Personal Emergency Response	
Other Service	Specialized Medical Equipment	
Other Service	Transportation	

## Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification Medicaid agency or the operating agency (if applicable).  Service Type:  Supports for Participant Direction	are readily available to CMS upon request through the
The waiver provides for participant direction of services as specif	ied in Appendix E. Indicate whether the waiver includes the
following supports or other supports for participant direction.	
Support for Participant Direction:	
Financial Management Services	to an interference for a file.
Alternate Service Title (if any):	AV 1940 AV 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
Financial Management Services	
HCBS Taxonomy:	

Category 1:		Sub-Category 1:
12 Services Supporting Self-Direction	<b>Y</b> :	12010 financial management services in support of self-direct
Category 2:		Sub-Category 2:
	V-	Selection and transit
Category 3:		Sub-Category 3:
	<b>V</b>	
Category 4:		Sub-Category 4:
	······································	· · · · · ·
ervice Definition (Scope):	. Andre A. Care San Care Andrew Andrews	annu de demo

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and will be available only to those who self direct. The FMS will enroll as a Medicaid Provider. The FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option. The FMS services are provided to ensure that the individualized budgets are managed and distributed according to the budget developed by each member and to facilitate the employment of service workers by members. The lowa Department of Human Services will

designate the Financial Management Service entities as organized health care delivery system.

Responsibilities of the financial management service. The financial management service shall perform all of the following

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the web-based tracking system chosen by the department and enter expenditures as they
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to IAC 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  - 1. Verifying that hourly wages comply with federal and state labor rules.
  - 2. Collecting and processing timecards.
- 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal

(FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

- 4. Computing and processing other withholdings, as applicable.
- 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal.

state, or local laws.

- 6. Preparing and issuing employee payroll checks.
- 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
- 8. Processing federal advance earned income tax credit for eligible employees.
- 9. Refunding over-collected FICA, when appropriate.
- 10. Refunding over-collected FUTA, when appropriate
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service	Delivery Method (check each that applies):
197	Participant-directed as specified in Appendix E Provider managed
Specify	whether the service may be provided by (check each that applies):
	Legally Responsible Person
	. Relative
	Legal Guardian

Provider Category	Provider Type Title
Agency	Financial Management Service

Provider Specifications:

1150		
Appendix	C: Participant Services C-1/C-3: Provider Specifications for Service	rekensistra kaharilka arkeelika da kaharin suuruk ke susi ada suurukan suur
	Type: Supports for Participant Direction	

Provider Category:	
Agency V	
Provider Type:	
Financial Management Service	
Provider Qualifications  License (specify):	
cheense rapeopy.	
Certificate (specify):	
2.20	, partie
Other Standard (specify):  As defined in IAC 441 Chapter 77.30(13), the financial inst (1) Be cooperative, nonprofit, member-owned and member chartered by either the National Credit Union Administration department of commerce; or (2) Be chartered by the Office of the Comptroller of the Cur Treasury, and insured by the Federal Deposit Insurance Conductor by the financial institution shall complete a financial management department or its designee.  c. The financial institution shall obtain an Internal Revenue dedicated to the financial management service.  d. The financial institution shall enroll as a Medicaid provide Verification of Provider Qualifications  Entity Responsible for Verification:  Iowa Department of Human Services, Iowa Medicaid Enter Frequency of Verification:  Every four years	controlled, and federally insured through and on (NCUA) or the credit union division of the Iowa rrency, a bureau of the U.S. Department of the reporation (FDIC).  Igement readiness review and certification conducted by Service federal employee identification number der.
Appendix C: Participant Services	
C-1/C-3: Service Specification	
State laws, regulations and policies referenced in the specification Medicaid agency or the operating agency (if applicable).  Service Type:  Supports for Participant Direction  The waiver provides for participant direction of services as specifollowing supports or other supports for participant direction.  Support for Participant Direction:  Information and Assistance in Support of Participant Direct Alternate Service Title (if any): Independent Support Broker	fied in Appendix E. Indicate whether the waiver includes the
HCBS Taxonomy:	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction $\checkmark$	12020 information and assistance in support of self-direction
Category 2:	Sub-Category 2:
	-marketing
	attend on Assistan
Category 3:	Sub-Category 3:
	Addition to addition.

Category 4:		Sub-Category 4:
	V:	yakman,
Service Definition (Scope):	rí Bro n cent	ered planning process and offer technical assistance and
The independent support broker shall perform the following representative:	, servi	ces as directed by the member or the member's
(1) Assist the member with developing the member's initial to the individual budget.	and s	ubsequent individual budgets and with making any changes
(2) Have monthly contact with the member for the first four have quarterly contact thereafter.	mont	hs of implementation of the initial individual budget and
<ul> <li>(3) Complete the required employment packet with the final</li> <li>(4) Assist with interviewing potential employees and entitie</li> <li>(5) Assist the member with determining whether a potential</li> <li>(6) Assist the member with obtaining a signed consent from by the member.</li> </ul>	s prov emple	iding services and supports if requested by the member.  byee meets the qualifications necessary to perform the job.
<ul> <li>(7) Assist the member with negotiating with entities providi</li> <li>(8) Assist the member with contracts and payment methods</li> <li>(9) Assist the member with developing an emergency backusafety concerns.</li> </ul>	for se	rvices and supports if requested by the member.
(10) Review expenditure reports from the financial manager budget are being provided.	ment s	ervice to ensure that services and supports in the individual
(11) Document in writing on the independent support broke documentation shall include information on the extent to whereast and the satisfaction of the member.	r time	card every contact the broker has with the member. Contact e member's individual budget has addressed the member's
Specify applicable (if any) limits on the amount, frequen The service is necessary for members who choose the self-direction option, the Independent Supp	lirection ort Br	on option at a minimum of 26 hours a year. When a member roker will be required to meet with the member at least mber needs additional support brokerage service, the member
Overlapping of services is avoided by the use of a service we system. The service worker is required to check to make su age of 21 before going to waiver services. Where there is a or the Rehabilitation Act of 1973.	re that	who manages all services and the entry into the ISIS EPSDT is used whenever possible for children under the tial for overlap, services must first be exhausted under IDEA
Service Delivery Method (check each that applies):		
<ul> <li>Participant-directed as specified in Appendix F</li> <li>Provider managed</li> </ul>	C	
Specify whether the service may be provided by (check e	ach th	at applies):
Legally Responsible Person  Relative  Legal Guardian		
Provider Specifications:		
Provider Category Provider Type Title Individual Individual Support Broker		
Appendix C: Participant Services C-1/C-3: Provider Specifications	for S	менения применения пр
Service Type: Supports for Participant Direction Service Name: Independent Support Broker		
Provider Category: Individual  Provider Type:		

Individual Cupport Dealear	
Individual Support Broker Provider Qualifications	
License (specify):	
Certificate (specify):	
Comman apecayy.	<u> </u>
Other Standard (specify):	
Members who elect the consumer choices option shall w	work with an independent support broker who meets the
following qualifications:  a. The broker must be at least 18 years of age.	
b. The broker shall not be the member's guardian, conse	rvator, attorney in fact under a durable power of attorney
for health care, power of attorney for financial matters, t	
<ul> <li>c. The broker shall not provide any other paid service to</li> <li>d. The broker shall not work for an individual or entity to</li> </ul>	
e. The broker must consent to a criminal background che	
results shall be provided to the member.	
<ul> <li>f. The broker must complete independent support broker</li> <li>Verification of Provider Qualifications</li> </ul>	age training approved by the department.
Entity Responsible for Verification:	
Financial Management System Provider, Iowa Departme	ent of Human Services, Iowa Medicaid Emerprise,
Provider Services Unit Frequency of Verification:	
	placed on an Independent Support Brokerage registry that
is maintained at the Iowa Department of Human Service	
Broker will be responsible for attending one support brok	ker training a year held at the HCBS regional meetings.
Verification of qualifications occurs every four years.	
Appendix C: Participant Services	
C-1/C-3: Service Specification	
State laws, regulations and policies referenced in the specifica-	tion are readily available to CMS upon request through the
Medicaid agency or the operating agency (if applicable).	and the state of the sport request the state of
Service Type:	
Supports for Participant Direction V	"" I' A TEPTE A LIGHT CONTROL
following supports or other supports for participant direction.	ecified in Appendix E. Indicate whether the waiver includes the
Support for Participant Direction:	
Other Supports for Participant Direction	
Alternate Service Title (if any): Individual Directed Goods and Services	
Individual Directed Goods and Services	
HCBS Taxonomy:	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	**************************************
112 Services Supporting Self-Direction	✓ 12020 information and assistance in support of self-direction
Category 2:	Sub-Category 2:
Category 2.	-
	C C C C C C C C C C C C C C C C C C C
Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:
program that address an assessed need or goal following requirements:  1. Promote opportunities for community living 2. Increase independence or substitute for hum human assistance.  3. Be accommodated within the member's bud 4. Be provided to the member or directed exche 5. Be the least costly to meet the member's need 6. Not be available through another source.  Participants (or guardians) who have chosen the employee supervision and training. Participant their service worker and ISB to budget service authority to terminate them as a provider of set Specify applicable (if any) limits on the amound individual directed goods and services must be	vices, equipment, or supplies not otherwise provided through the Medicaid identified in the member's service plan. The item or service shall meet the g and inclusion.  In an assistance, to the extent the expenditures would otherwise be made for that diget without compromising the member's health and safety. Usively toward the benefit of the member.  In self-direction program must be willing to take on the responsibility of the or their guardians must review all time cards to ensure accuracy and work with the self-direction program is not satisfied with the work of their employee, they have full revices.
the conference, meeting or similar venue.  4. Costs associated with shipping items to the solution of the solu	need. ses other than the costs of approved services the member needs while attending member. cations, therapies, or treatments.
<ul><li>20. Sheltered workshop services.</li><li>21. Social or recreational purchases not related</li></ul>	
Service Delivery Method (check each that ap	pplies):
Participant-directed as specified in Provider managed	a Appendix E

Specify whether the service may be provided by (check each that applies):

- 🔀 Legally Responsible Person
- ✓ Relative
- 🔀 Legal Guardian

### Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or businesses

Appendix C: Participant Services

# C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction Service Name: Individual Directed Goods and Ser	vices
Provider Category:	
Individual V	
Provider Type:	
Individual or businesses	
Provider Qualifications	
License (specify):	
	pports shall have all the necessary licenses required by
federal, state and local laws and regulations.	
Certificate (specify): Businesses providing individual-directed goods and s	pervices must have current liability and workers?
compensation coverage.	solvices that have earlest hability and workers
Other Standard (specify):	
	18 years of age. All persons must be able to demonstrate to
the member the ability to successfully communicate v	
Verification of Provider Qualifications	
Entity Responsible for Verification:	
The member, independant support broker, and the fin	ancial management service.
Frequency of Verification:	
Every four years	
Appendix C: Participant Services C-1/C-3: Service Specification	
O In C of Soft too Spootsteadon	
Medicaid agency or the operating agency (if applicable).  Service Type:  Supports for Participant Direction   The waiver provides for participant direction of services as following supports or other supports for participant direction.	fication are readily available to CMS upon request through the s specified in Appendix E. Indicate whether the waiver includes the on.
Support for Participant Direction:	entropy and the control of the contr
Other Supports for Participant Direction	V :
Alternate Service Title (if any): Self Directed Personal Care	
Bell Diffeded Letsorial Care	
HCBS Taxonomy:	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	✓ 12020 information and assistance in support of self-direction
Category 2:	Sub-Category 2:
	× 1
Category 3:	Sub-Category 3:
	The control of the co
Category 4:	Sub-Category 4:
25 Lab 2 (2004) 25 C (2004) 25	
Service Definition (Scope):	

Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community that they would normally do themselves if they did not have a disability; activities of daily living and incidental activities of daily living that help the person remaining the home and in their community. This assistance may take the form of hands-on assistance (actually performing a task for a person) or cuing to prompt the participant to perform a task. Personal care may be provided on an episodic or on a continuing basis.

Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law. These services are only available for those that self-direct. The member will have budget authority over self-directed personal care services. The dollar amount available for this service will be based on the needs identified on the service plan. Overlapping of services is avoided by the use of a case manager who manages all services and the entry into the ISIS system. The case manager and interdisciplinary team determine which service is necessary and authorize transportation for both HCBS and self-directed services.

Participants (or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their case manager and ISB to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Self-directed personal care services need to be identified on the individual budget plan. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate will be applied to the individual budget amount. Transportation costs within this service is billed separately and not included in the scope of personal care. Please see Section E-2- b ii. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

Service Delivery Method (check each that applies):

					_
. 1	Participant-directed	as specified	in	Appendix	К

Provider managed

Specify whether the service may be provided by (check each that applies):

- 😺 Legally Responsible Person

#### **Provider Specifications:**

1	Provider Category	Provider Type Title	
	Individual	Individual or businesses	

### Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Self Directed Personal Care

#### Provider Category:

Individual 🗸

#### Provider Type:

Individual or businesses

#### Provider Qualifications

License (specify):

Individuals and businesses providing services shall have all the necessary licenses required by federal, state and local laws and regulations.

#### Certificate (specify):

Businesses shall have current liability and workers' compensation coverage.

#### Other Standard (specify):

All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. The member and the independent support broker are responsible for determining provider qualifications for the individual employees identified on the individual budget.

#### Verification of Provider Qualifications

#### Entity Responsible for Verification:

The member, the independent support broker, and the financial management service

#### Frequency of Verification:

Every four years

### Appendix C: Participant Services

### C-1/C-3: Service Specification

Σ	
State laws, regulations and policies referenced in the specif Medicaid agency or the operating agency (if applicable).	ication are readily available to CMS upon request through the
Service Type:	
Supports for Participant Direction ✓	
The waiver provides for participant direction of services as following supports or other supports for participant directio	specified in Appendix E. Indicate whether the waiver includes the n.
Support for Participant Direction:	
Other Supports for Participant Direction	
Alternate Service Title (if any):	. or to 1.5 to to to to 1.5 to
Self-directed Community Support and Employment	
HCBS Taxonomy:	

Category 1:		Sub-Category 1:
12 Services Supporting Self-Direction	×:	12020 information and assistance in support of self-direction
Category 2:		Sub-Category 2:
	$\checkmark$	
Category 3:		Sub-Category 3:
	<b>L</b>	
Category 4:		Sub-Category 4:
	~:	——————————————————————————————————————

#### Service Definition (Scope):

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. They include ongoing supports to member who because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. These services must be identified in the member's service plan developed by the member's service worker. Services may include payment for social skills development, career placement, vocational planning, and independent daily living activity skill development. The outcome of this service is to maintain integrated living in the community or to sustain competitive employment at or above the state's minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2) payments that are passed through to users of supported employment services.

Transportation may be covered for members from their place of residence and the employment site as a component of this service and the cost may be included in the rate.

The following are examples of supports a member can purchase to help the member live and work in the community:

- o Career counseling
- o Career preparation skills development
- o Cleaning skills development
- o Cooking skills development
- o Grooming skills development
- o Job hunting and career placement
- o Personal and home skills development

- o Safety and emergency preparedness skills development
- o Self-direction and self-advocacy skills development
- o Social skills development training
- o Supports to attend social activities
- o Supports to maintain a job
- o Time and money management
- o Training on use of medical equipment
- o Utilization of public transportation skills development
- o Work place personal assistance

Members(or guardians) who have chosen the self-direction program must be willing to take on the responsibility of employee supervision and training. Participants or their guardians must review all time cards to ensure accuracy and work with their service worker and independent support broker (ISB) to budget services. If a participant is not satisfied with the work of their employee, they have full authority to terminate them as a provider of services.

Documentation is maintained in the file of each individual receiving service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C 1401 et seq.). The service worker will monitor the plan.

### Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community support and employment services must be identified on the individual budget plan. The individual budget limit will be based on the member's authorized service plan and the need for the services available to be converted to the CCO budget. The waiver allows for the following five waiver services to be converted to create a CCO budget:

- 1. Consumer-directed attendant care (unskilled).
- 2. Home and vehicle modification.
- 3. Basic individual respite care.
- 4. Home delivered meals.
- 5. Homemaker services.

A utilization adjustment rate is applied to the individual budget amount. Please see Section E- 2- b ii for details on how the CCO budget is created. Authorization of this service must be made after assuring that there is no duplication or overlapping of state plan services.

Service Delivery	Method	(check each	that applies):
------------------	--------	-------------	----------------

. <del>.</del>	Participant-directed as specified in Appendix E
 	Provider managed
Specify	whether the service may be provided by (check each that applies,
 :~/	Legally Responsible Person

**Provider Specifications:** 

Relative ✓ Legal Guardian

Provider Category	Provider Type Title
Individual	Individual or businesses

Individual	Individual or businesses	
Appendix C:	: Participant Services	
THE REPORT OF THE PARTY OF THE		
( -	1/C-3: Provider Specifications for Service	
Carrier Trans	Comparts for Boutisinant Dissection	
	pe: Supports for Participant Direction	
Service Nan	me: Self-directed Community Support and Employment	
Provider Catego	ory:	
Individual 🗸:		
Provider Type:		
Individual or bus	inesses	
Provider Qualifi	ications	
License (spe	ecify):	
		<b>*</b>
an and an and an		**************************************
Certificate	(enazifu):	
Certificate	13PC-UYI.	
1		15.00
į		***

#### Other Standard (specify):

Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements:

- A business providing community supports and employment shall:
- (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and
- (2) Have current liability and workers' compensation coverage as required by law.
- · All personnel providing individual-directed community supports and employment shall:
- (1) Be at least 18 years of age.
- (2) Be able to communicate successfully with the member.
- (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.
- (5) Not be the parent or stepparent of a minor child member or the spouse of a member.
- •The provider of individual-directed community supports and employment shall:
- (1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.
- (2) Submit invoices and time sheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and time sheets are received after this 30-day period.

#### Verification of Provider Qualifications

#### Entity Responsible for Verification:

the member, the independent support broker, and the financial management service

#### Frequency of Verification:

Every four years

Category 4:

Service Definition (Scope):

### Appendix C: Participant Services

C-1	I/C-3: Service Specification		
	tions and policies referenced in the specifi or the operating agency (if applicable).	cation	n are readily available to CMS upon request through the
Other Service	<u> </u>		thority to provide the following additional service not specified
in statute. Service Title:	ed Attendant Care (Skilled)	ie aui	inority to provide the following additional service not specified
HCBS Taxonom	y:		
Category 1:			Sub-Category 1:
08 Home-E	Based Services	<u> </u>	08010 home-based habilitation 🗸
Category 2:			Sub-Category 2:
The PERSON SET OF THE PERSON S		<b></b> :	No.
Category 3:			Sub-Category 3:

Sub-Category 4:

Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision

The skilled activities are listed as follows:

Skilled services. Covered skilled service activities are limited to help with the following activities: (1) Tube feedings of members unable to eat solid foods. (2) Intravenous therapy administered by a registered nurse. (3) Parenteral injections required more than once a week. (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required. (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator. (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist. (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living. (8) Colostomy care. (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions. (10) Postsurgical nursing care. (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics. (12) Preparing and monitoring response to therapeutic diets. (13) Recording and reporting of changes in vital signs to the nurse or therapist

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list): (1) Any activity related to supervising a member. Only direct services are billable. (2) Any activity that the member is able to perform. (3) Costs of food. (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services. (5) Exercise that does not require skilled services. Ch 78, p.100 Human Services[441] IAC 7/5/17 (6) Parenting or child care for or on behalf of the member. (7) Reminders and cueing. (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services. (9) Transportation costs. (10) Wait times for any activity.

Service Delivery Method (check each that applies):

- ✓ Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- 🗸 Legally Responsible Person
- Relative
- Legal Guardian

### **Provider Specifications:**

Provider Category	Provider Type Title
Agency	Chore Provider
Agency	Community Action Agencies
Адевсу	Home Care Provider
Адевсу	Supported Community Living Providers
Individual	Any individual who contracts with the member
Agency	Home Health Agency
Agency	Adult Day Service Provider
Адепсу	Assisted living Program

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer-Directed Attendant Care (Skilled)

Provider Category:

Agency 🗸

Provider Type:

Chore Provider

**Provider Qualifications** 

License (specify):

Certificate (specify):

Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services. 441 IAC 77.30(7)d

Other Standard (specify):

Providers must be:

- 1. At least 18 years of age, and
- 2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
- 3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
- 4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- 5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department the specific standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

#### Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

### Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer-Directed Attendant Care (Skilled)

#### Provider Category:

Agency >

Provider Type:

Community Action Agencies

#### **Provider Qualifications**

License (specify):

Certificate (specify).

Community Action Agencies as designated in Iowa Code 216A.93.

Other Standard (specify):

The community agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

### Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

### Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer-Directed Attendant Care (Skilled)

#### Provider Category:

Agency 🗸

Provider Type:

Home Care Provider

Provider Qualifications

License (specify):	***************************************
Certificate (specify):  Home care providers that have a contract with the department of public health or have written certificate the department of public health stating they meet the home care standards and requirements set forth in Administrative Code 641—80.3(5),—80.3(6), and 80.3(7).  Other Standard (specify):  Providers must be:  1. At least 18 years of age, and  2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved pla 3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.  4. Not the recipient of respite services paid through home- and community-based services on behalf of who receives home- and community-based services.  5. All CDAC provider applicants must go through a criminal and adult/child abuse background check penrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has abuse record.	n. a member
For this service the department specifies standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensur contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.  Verification of Provider Qualifications  Entity Responsible for Verification:  lowa Department of Human Services, lowa Medicaid Enterprise, Provider Services Unit Frequency of Verification:  Every four years	e that the
Appendix C: Participant Services	
C-1/C-3: Provider Specifications for Service	
Service Type: Other Service	
Service Name: Consumer-Directed Attendant Care (Skilled)	
Provider Category:  Agency Provider Type: Supported Community Living Providers Provider Qualifications License (specify):	
	yet in
Certificate (specify): Providers certified by the Department's Home and Community Based Services Quality Oversight Unit Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in 1 Chapters 77.37 and 77.39.  Other Standard (specify):	
	A
Verification of Provider Qualifications Entity Responsible for Verification: Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit Frequency of Verification: Every four years	<u> </u>
Annandiv C. Barticinant Sarvices	
Appendix C: Participant Services  C-1/C-3: Provider Specifications for Service	
Service Type: Other Service	
Service Type: Other Service Service Name: Consumer-Directed Attendant Care (Skilled)	

Provider Category:
Individual V
Provider Type: Any individual who contracts with the member
Provider Qualifications Lingua (month):
License (specify):
Certificate (specify):
Other Standard (specify):  An individual who contracts with the member to provide attendant care service and who is:  1. At least 18 years of age, and  2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.  3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.  4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.
For this service the department specifies standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.  Verification of Provider Qualifications  Entity Responsible for Verification:
Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit  Frequency of Verification:  Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service Service Name: Consumer-Directed Attendant Care (Skilled)
Provider Category:
Agency
Provider Type: Home Health Agency
Provider Qualifications
License (specify):
Certificate (specify): In accordance with IAC 441-Chapter 77: home health agencies are eligible to participate with Iowa Medicaid provided they are certified to participate in the Medicare program (Title XVII of the Social Security Act sections 1861(o) and 1891). These sections establish the conditions that a home health agency must meet in order to participate in Medicare.  Other Standard (specify):
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit Frequency of Verification: Every four years
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Appendix C: Participant Services

## C-1/C-3: Provider Specifications for Service

Service Type: Other Service Service Name: Consumer-Directed Attendant Care (Skilled)	
Provider Category:	
Agency V	
Provider Type:	
Adult Day Service Provider	
Provider Qualifications	
License (specify):	
grant purp and the control of the co	Way.
	***
Certificate (specify):	
Adult day service providers that are certified by the Department of Inspections and Appeals under 481—	-Chapter
70.	
Other Standard (specify):	····
	No.
	انوا
Verification of Provider Qualifications	
Entity Responsible for Verification:	
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit	
Frequency of Verification:	
Every four years	
Appendix C: Participant Services	ADDRESS OF THE OWNER OF THE OWNER.
C-1/C-3: Provider Specifications for Service	
Service Type: Other Service	
Service Name: Consumer-Directed Attendant Care (Skilled)	
Provider Category:	
Agency	
Provider Type:	
Assisted living Program	
Provider Qualifications	
License (specify):	
	A
	* <u>-</u>
Certificate (specify):	
Assisted living programs that are certified by the Iowa department of inspections and appeals under 481-	—Chapter
69.	
Other Standard (specify):	
	444
Verification of Provider Qualifications	
Entity Responsible for Verification:	
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit	
Frequency of Verification:	
Every four years	
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Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable). Service Type:

**************************************	
:Other Service	Saper .

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

#### Service Title:

Consumer-Directed Attendant Care (Unskilled)

#### HCBS Taxonomy:

Category 1:	Sub-Category 1:
	. X
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
	: <del>V</del>
Category 4:	Sub-Category 4:

Service Definition (Scope):

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Consumer-directed attendant care may occur in the member's home or community.

The service activities may include helping the member with any of the following nonskilled service activities:

- (1) Dressing.
- (2) Bath, shampoo, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- (4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
- (5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.
- (6) Housekeeping services which are essential to the member's health care at home.
- (7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
- (8) Wound care.
- (9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Cognitive assistance with tasks such as handling money and scheduling.
- (11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
- (12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

A unit of services is 15 minutes. Services are billed in whole units. There are upper rate limits wheih are subject to change on a yearly basis.

#### Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The first line of prevention of duplicative billing for similar types of services, such as home health aide, is the member's case manager. The case manager is responsible for the authorization and monitoring of services in a member's plan of care. If the case manager authorizes similar services, they are responsible to assure that the services are being delivered as ordered. The ISIS system generates a review report to assist the case manager. The report identifies all services that have been billed for a specific time period (ex. one month). The case manager is able to view the service billed to the individual member, the amount of the service billed and the provider. The case manager is able to compare what has been billed by the provider to

what is ordered in the plan of care. The department also conducts post audit reviews of providers to review the billing of providers to assure that the services provided have documentation to support the billing.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- ✓ Provider managed

Specify whether the service may be provided by (check each that applies):

- 🔀 Legally Responsible Person
- ✓ Relative
- 🗸 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day service providers
Agency	Home Health Agency
Agency	Chore provider
Individual	Any individual who contracts with the member
Agency	Community Action Agency
Agency	Assisted Living Programs
Agency	Supported Community Living provider
Agency	Home Care Provider

Appendix C: I	Participant	Services
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C-1/C-3: Provider Specifications for Service

Service Name: Consumer-Directed Attendant Care (Unskilled)

P	ro	vid	er	Cat	ego	ry:

Agency V

Provider Type:

Adult Day service providers

#### Provider Qualifications

License (specify):

Certificate (specify):

Adult Day service providers certified by the Department of Inspections and Appeals under IAC 481 - Chapter 70.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer-Directed Attendant Care (Unskilled)

Provider Category:

Agency 🗸

Provider Type:

Home Health Agency

Certificate (specify):

Chore provider subcontracting with area agencies on aging with letters from the area agencies on aging stating that the organization is qualified to provide chore services.

IAC 17-4.4(231) Area agencies on aging.

4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements.

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

#### Other Standard (specify):

Providers must be:

- 1. At least 18 years of age, and
- 2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
- 3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
- 4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- 5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department specifies standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

# Verification of Provider Qualifications

#### Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service
Service Name: Consumer-Directed Attendant Care (Unskilled)
Provider Category:
Individual V
Provider Type:
Any individual who contracts with the member
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
An individual who contracts with the member to provide attendant care service and who is:
1. At least 18 years of age, and
2. Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.
<ul><li>3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.</li><li>4. Not the recipient of respite services paid through home- and community-based services on behalf of a member</li></ul>
who receives home- and community-based services paid through nome- and community-based services on behalf of a member
5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to
enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded
abuse record.
For this service the department specifies standards for subcontracts or providers regarding training, age
limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the
contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure
services are provided in a safe and effective manner.  Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service
Service Name: Consumer-Directed Attendant Care (Unskilled)
Provider Category:
: Agency 💙
Provider Type:
Community Action Agency
Provider Qualifications
License (specify):
Certificate (specify):
Community action agencies as designated in Iowa Code section 216A.93.  Other Standard (specify):
Providers must be:
(1) At least 18 years of age.
(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-
approved case plan or individual comprehensive plan

- (3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
- (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives respite services.

The community agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

The CDAC provider must enter into an agreement with the member receiving services, such that there is a plan to provide medically necessary and approved CDAC services to the member on a recurring basis within the parameters of the service plan, CDAC agreement, and provider standards.

The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

#### Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprises, Provider Services Unit

Frequency of Verification:

Every four years

### Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer-Directed Attendant Care (Unskilled)

#### Provider Category:

Agency 🗸

Provider Type:

Assisted Living Programs

#### Provider Qualifications

License (specify):

Certificate (specify):

Assisted living programs that are certified by the Department of Inspections and Appeals under IAC 481—Chapter 69.

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.

"Accredited" means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).

"Nonaccredited" means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).

481--69.14(231C) Recognized accrediting entity.

69.14(1) The department designates CARF as a recognized accrediting entity for programs.

69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.

69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.

69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

For this service the department does not have specific standards for subcontracts or providers regarding training.

age limitations, experience or education. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
Other Standard (specify):
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service
Service Type: Other Service Service Name: Consumer-Directed Attendant Care (Unskilled)
Provider Category:
:Agency Y
Provider Type: Supported Community Living provider
Provider Qualifications
License (specify):
Certificate (specify):
Providers certified by the Department's Home and Community Based Services Quality Oversight Unit to provide
Supported Community Living under the Intellectual Disability or Brain Injury Waiver as described in IAC 441 Chapters 77.37 and 77.39.
Other Standard (specify):
A
Y C. C. C. D. H. C. H. C.
Verification of Provider Qualifications  Entity Responsible for Verification:
Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service
Service Name: Consumer-Directed Attendant Care (Unskilled)
Provider Category:
Agency Y
Provider Type: Home Care Provider
Provider Qualifications
License (specify):
Certificate (specify):
Home care providers that have a contract with the department of public health or have written certification from
the department of public health stating they meet the home care standards and requirements set forth in lowa
Administrative Code 641—80.3(5),—80.3(6), and 80.3(7).  Other Standard (specify):
Providers must be:
1. At least 18 years of age, and
<ol><li>Qualified or trained to carry out the member's plan of care pursuant to the department's approved plan.</li></ol>

- 3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
- 4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- 5. All CDAC provider applicants must go through a criminal and adult/child abuse background check prior to enrollment. A provider may be disenrolled if an individual is convicted of any criminal activity or has a founded abuse record.

For this service the department specifies standards for subcontracts or providers regarding training, age limitations, experience or education are indicated above. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

#### Verification of Provider Qualifications

#### Entity Responsible for Verification:

lowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

#### Frequency of Verification:

Every four years

Appendix	C:	Participant	Services
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### C-1/C-3: Service Specification

State laws, regulations and policies	referenced in the specification are readily available to CMS upon request through the
Medicaid agency or the operating a	
Service Type:	
Other Service	¥.
As provided in 42 CFR §440.180(b	0(9), the State requests the authority to provide the following additional service not specified
in statute.	
Service Title:	
Home and Vehicle Modification	

#### HCBS Taxonomy:

Category 1:		Sub-Category 1:
.14 Equipment, Technology, and Modifications		14020 home and/or vehicle accessibility adaptations 🗸
Category 2:		Sub-Category 2:
	✓.	JAMANANA MAAA
Category 3:		Sub-Category 3:
	· ·	
Category 4:		Sub-Category 4:
	<b>V</b>	: 🗸

Service Definition (Scope):

Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

- a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle modifications are not furnished to adapt living arrangements that are owned or leased by providers of waiver services. Modifications may be made to privately owned rental properties. Home and vehicle repairs are also excluded. Purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle is not allowable.
- b. Only the following modifications are covered:
- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and

accessible showers and sink areas.

- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes. Services shall be performed following prior department approval of the modification as specified in 441 - sub-rule 79.1 (17) and a binding contract between the provider and the member. All contracts for home or vehicle modification shall be awarded through competitive bidding.

Home modifications will not be furnished to adapt living arrangements that are owned or leased by providers of waiver services including an assisted living facility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The services under Home and Vehicle Modifications are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

A unit of service is the completion of needed modifications or adaptations. HVM within the PD waiver is limited to a \$6,366.64 per year. The member's plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan by the service worker.

When the member has reached the upper limit of \$6,366.64 per year, the service worker may assist the member to seek out other funding streams that may be available to assist them such as grants or other volunteer agencies that my assist.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- 👿 Legally Responsible Person
- 求 Legal Guardian

#### Provider Specifications:

Provider Category	Provider Type Title	
Agency	Community Business	
Agency	HVM Providers Enrolled under Other Waivers	
Agency	Area Agencies on Aging	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home and Vehicle Modification
Provider Category:
Agency ✓.
Provider Type:
Community Business
Provider Qualifications
License (specify):
441 IAC 77.30(9)"d" - Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and
workers' compensation insurance.
Certificate (specify):
***
Other Standard (specify):
in the second of
Verification of Provider Qualifications
Entity Responsible for Verification:
lowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service Service Name: Home and Vehicle Modification
Provider Category:
: Agency ✓.
Provider Type:
HVM Providers Enrolled under Other Waivers  Provider Qualifications
License (specify):
A Commence of the commence of
Certificate (specify):
£.
Other Standard (specify):
Providers enrolled to participate as HVM providers under the Brain Injury, Elderly, Health and Disability, and
Intellectual Disability Waivers as described in 441 IAC Chapter 77.
For this service the department does not have specific standards for subcontracts or providers regarding training,
age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service
workers are responsible to monitor service provision to ensure services are provided in a safe and effective
manner.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
C-1/C-3, 1 fuvidel specifications for Science
Carries Type, Other Carries
Service Type: Other Service Service Name: Home and Vehicle Modification

rovider Calegory:	
Agency Y	
Provider Type:	
Area Agencies on Aging	
Provider Qualifications	
License (specify):	
	je de la companya de
	*
Certificate (specify):	rannonakwanan en wonon na wononka wannona wononka kaide
Area agencies on aging as designated according to department on aging rules IAC 17—4.4(231)	

IAC 17—4.4(231)Area agencies on aging.

4.4(1)Designation. The department shall designate for each planning and service area an entity to serve as the area agency on aging in accordance with Older Americans Act requirements. The department may, in its discretion, designate one area agency on aging to serve more than one planning and service area.4.4(2)Designation requirements for units of general purpose local government. Whenever the department designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984 or designates an existing area agency on aging, the department shall give the right of first refusal to a unit of general purpose local government if:

a. The unit of general purpose local government can meet the requirements established to serve as an area agency on aging pursuant to state and federal law; and

b. The unit of general purpose local government's geographical boundaries and the geographical boundaries of the planning and service area are reasonably contiguous.

4.4(3)Qualifications to serve. Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:

a. An established office of aging operating within a planning and service area;

b.Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;

c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;

d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or

e.Any other entity authorized by the Older Americans Act.

4.4(8)Official designation. An entity shall be designated the area agency on aging upon the commission's acceptance of the department's proposed recommendation for designation, the commission's approval of the area agency on aging area plan, and execution of the associated contract between the department and the area agency on aging. Official designation of an area agency on aging shall not occur until final disposition of all appeals.

Other Standard (specify):

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

### Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department Of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

### Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service  As provided in 42 CFR §440.180(b)(9), the State requests the autin statute.  Service Title: Personal Emergency Response	hority to provide the following additional service not specified
HCBS Taxonomy:	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS) 🗸
Category 2:	Sub-Category 2:
	Sample of the sa
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope):	Secretary,
summon assistance in the event of an emergency. The necessary of 1. An in-home medical communications transceiver.  2. A remote, portable activator.  3. A central monitoring station with backup systems staffed by trade. Current data files at the central monitoring station containing reinformation for each member.	ained attendants at all times. esponse protocols and personal, medical, and emergency
A portable locator system is an electronic device that transmits a access assistance in the event of an emergency and allows law en member who is unable to request help or to activate a system inde in an emergency situation due to the member's age or disability. 1. A portable communications transceiver or transmitter to be wo 2. Monitoring by the provider at a central location with response for each member as applicable.	forcement or the monitoring system provider to locate a ependently. The member must be unable to access assistance. The required components of the portable locator system are: rn or carried by the member.
Provider staff are responsible for training members regarding the charges for installation or monthly fee, depending upon how the pworkers would also assist members in understanding how to utiliz Specify applicable (if any) limits on the amount, frequency, or A unit of service is a one time installation fee or month of service installation and 12 months of service. The member's plan of care Services must be authorized in the service plan. The service work	provider structures their fee schedule. If necessary, service ze the system.  r duration of this service:  Maximum units per state fiscal year shall be one initial will address how the member's health care needs are met.
Service Delivery Method (check each that applies):	
Participant-directed as specified in Appendix E  Provider managed	
Specify whether the service may be provided by (check each the	nat applies):
Legalty Responsible Person	
Relative  Legal Guardian	
Legal Guardian Provider Specifications:	
Provider Catagory Provider Type Title	

Emergency Response System Providers

Agency

Appendix C: Participant Services C-1/C-3: Provider Specifications for	recuprocurrence construction de la final de la construction de la cons
Service Type: Other Service Service Name: Personal Emergency Response	
Provider Category: Agency Provider Type: Emergency Response System Providers Provider Qualifications	
License (specify):	
Certificate (specify):	
Other Standard (specify): Agencies which meet the conditions of participation for Ex Iowa Administrative Code 77.33(2).	nergency Response System Providers as set forth in
<ul> <li>a. The agency shall provide an electronic component to tratelephone lines to a central monitoring station. The central and be fully staffed by trained attendants, 24 hours a day, semergency calls and ensure the timely notification of approperson in need.</li> <li>b. The agency, parent agency, institution or corporation shaconformity with federal, state and local laws and regulation c. There shall be a governing authority which is responsible of services and finances. The governing authority shall emauthority and responsibility for overall agency administration. The agency or institution shall be in compliance with all</li> </ul>	monitoring station must operate receiving equipment even days per week. The attendants must process opriate emergency resources to be dispatched to the all have the necessary legal authority to operate in as.  e for establishing policy and ensuring effective control ploy or contract for an agency administrator to whom on are delegated.
practices. e. There shall be written policies and procedures established responsibilities, client responsibilities and cost information.  Verification of Provider Qualifications.  Entity Responsible for Verification:  Iowa Department of Human Services, Iowa Medicaid Enter Frequency of Verification:  Every four years	L.
Appendix C: Participant Services C-1/C-3: Service Specification	30 Springs van State van State van de State van State
State laws, regulations and policies referenced in the specification Medicaid agency or the operating agency (if applicable).  Service Type:  Other Service  As provided in 42 CFR §440.180(b)(9), the State requests the autin statute.  Service Title:  Specialized Medical Equipment	
HCBS Taxonomy:	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2:	Sub-Category 2:
	Ana-December 100*
Category 3:	Sub-Category 3:
	Service and
Category 4:	Sub-Category 4:
	Street Construction Constructio
Service Definition (Scope):  1. Specialized medical equipment includes the following: a. Medical equipment devices that will improve assessed function live independently in the community. b. The cost to repair medical equipment devices identified in "a."	
2. Specialized medical equipment devices are not duplicative of r devices covered through vocational rehabilitation, education, thir Specify applicable (if any) limits on the amount, frequency, of Payment of up to \$6,366.64 per year may be made to enrolled spereceipt of the service. Each month within the 12-month period, the dollar cap allowed for the member until the amount of the equipment after assuring that there is no duplication or overlapping of Rehabilitation Act of 1973 are not available.	d party insurance or other available funding sources.  r duration of this service: ecialized medical equipment providers upon satisfactory the service worker can encumber an amount within the monthly ment cost is reached. Authorization of this service must be
Service Delivery Method (check each that applies):	
Participant-directed as specified in Appendix E Provider managed	
Specify whether the service may be provided by (check each the	nat applies):
Legally Responsible Person	
Relative	
Legal Guardian	
Provider Specifications:	
Provider Category Provider Type Title	
Agency Medical Equipmentand supply dealers	
Agency Retail and wholesale businesses	
Appendix C: Participant Services	
C-1/C-3: Provider Specifications for	миниворительного положения
Service Type: Other Service	
Service Name: Specialized Medical Equipment	
Provider Category:	
Provider Type:	
Medical Equipmentand supply dealers	
Provider Qualifications	
License (specify):	
* Avenue and the second and the seco	
Certificate (specify):	
	*
ALLE APPRILITATION OF THE PROPERTY OF THE PROP	
Other Standard (specify):  Medical equipment and supply dealers participating in the N	Andigaid program Those provides and be asset by
Medicare providers to enroll with lowa Medicaid.	Actional program. These providers must be emoned as

https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.jsp

For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

#### Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

Frequency of Verification:

Every four years

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service
Service Name: Specialized Medical Equipment
Provider Category:
Agency
Provider Type:
Retail and wholesale businesses
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized
medical equipment as defined in IAC 44178.46(4).
For this service the department does not have specific standards for subcontracts or providers regarding training, age limitations, experience or education, other than what would be contained in statute or administrative rules for this provider. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.  Verification of Provider Qualifications  Entity Responsible for Verification:  Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit Frequency of Verification:  Every four years  Appendix C: Participant Services  C-1/C-3: Service Specification
C-1/C-3. Service Specification
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).  Service Type:  Other Service  As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specifie in statute.  Service Title:  Transportation
HCBS Taxonomy:

15 Non-Med			Sub-Category 1:
	dical Transportation	··········	· 15010 non-medical transportation ✓
Category 2:			Sub-Category 2:
		V	
Category 3:			Sub-Category 3:
v/************************************		A. S.	waterweet.
(propries services and all the		~	
Category 4:			Sub-Category 4:
		V	
unit of service is	ialshopping, to travel to and from work or s one mile of transportation or one one-way e (if any) limits on the amount, frequence	trip	
			and the second s
rvice Delivery	Method (check each that applies):		
27 Particin	ant-directed as specified in Appendix E		
Z Provide			
ecify whether t	the service may be provided by (check ea	ch th	at applies):
T II	Responsible Person		
	•		
Relative			
Relative Legal G	uardian	•	
Relative	uardian ations:		
Relative Legal G	uardian ations: gory Provider Type Title	o consideración de la cons	
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Relative Legal G ovider Specific  Provider Categ Agency Agency Agency Agency Agency Agency Agency C Service Typ	puardian ations:  gory Provider Type Title Area Agencies on Aging County Contracted Transportation Provid Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies  Participant Services  1/C-3: Provider Specifications:		
Relative Legal G ovider Specific  Provider Categ Agency Agency Agency Agency Agency Agency Agency C Service Typ	puardian ations:  pory Provider Type Title Area Agencies on Aging County Contracted Transportation Provid Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies Participant Services 1/C-3: Provider Specifications: e: Other Service ne: Transportation		
Relative Legal G ovider Specific  Provider Catego Agency	puardian ations:  pory Provider Type Title Area Agencies on Aging County Contracted Transportation Provid Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies Participant Services 1/C-3: Provider Specifications: e: Other Service ne: Transportation		
Relative Legal G ovider Specific  Provider Catego Agency	puardian ations:  pory Provider Type Title Area Agencies on Aging County Contracted Transportation Provided Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies Participant Services 1/C-3: Provider Specifications of the Contraction of the Contra		
Relative Legal G ovider Specific  Provider Catego Agency Forvider Type:	puardian ations:  pory Provider Type Title Area Agencies on Aging County Contracted Transportation Provider Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies Participant Services 1/C-3: Provider Specifications:  e: Other Service ne: Transportation ry:		
Relative Legal G ovider Specific  Provider Catego Agency October Type: Tea Agencies on rovider Qualifit	puardian ations:  pory Provider Type Title Area Agencies on Aging County Contracted Transportation Provid Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies Participant Services 1/C-3: Provider Specifications:  e: Other Service ne: Transportation ry:  Aging cations		
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Relative Legal G ovider Specific  Provider Catego Agency October Type: Tea Agencies on rovider Qualifit	puardian ations:  pory Provider Type Title Area Agencies on Aging County Contracted Transportation Provid Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies Participant Services 1/C-3: Provider Specifications:  e: Other Service ne: Transportation ry:  Aging cations		
Relative Legal G ovider Specific  Provider Catego Agency October Type: Tea Agencies on rovider Qualifit	puardian ations:  gory Provider Type Title Area Agencies on Aging County Contracted Transportation Provided Nursing Facilities Provider Contracting with NEMT Regional Transit Agencies HCBS Provider Agencies Community Action Agencies  Participant Services 1/C-3: Provider Specifications:  e: Other Service ne: Transportation ry:  Aging cations ecify):		

#### Other Standard (specify):

Area agencies on aging as designated in 17 IAC —4.4(231): Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans Act and Iowa Code chapter 231. An area agency on aging shall be any one of the following:

a. An established office of aging operating within a planning and service area;

b. Any office or agency of a unit of general number local government, which is designated to function

b. Any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;

c. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;

d. Any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which for designation purposes is under the supervision or direction of the department and which can and will engage only in the planning or provision of a broad range of supportive services or nutrition services within such planning and service area; or

e. Any other entity authorized by the Older Americans Act.

OI

2) with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

#### Verification of Provider Qualifications

#### Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit

#### Frequency of Verification:

Every four years

Provider Type:

C-1/C-3: Provider Specifications for Service	
Service Type: Other Service	
Service Name: Transportation	
Provider Category:	
Agency	
Provider Type:	
County Contracted Transportation Provider	
Provider Qualifications	
License (specify):	
Certificate (specify):	
	أ بدهم
	أ العن ا
Other Standard (specify): Transportation providers that contract with county governments. For this service	the department does not have
Other Standard (specify):  Transportation providers that contract with county governments. For this service specific standards for subcontracts or providers regarding training, age limitations than what would be contained in statute or administrative rules for this provider. It transportation providers are responsible to ensure that their employees are qualified workers are responsible to monitor service provision to ensure services are provided manner.  Verification of Provider Qualifications  Entity Responsible for Verification:  Iowa Department of Human Services, lowa Medicaid Enterprise, Provider Services Frequency of Verification:  Every four years	, experience or education, other The county contracted ed, trained and reliable. Service ed in a safe and effective
Transportation providers that contract with county governments. For this service specific standards for subcontracts or providers regarding training, age limitations than what would be contained in statute or administrative rules for this provider. transportation providers are responsible to ensure that their employees are qualific workers are responsible to monitor service provision to ensure services are provided manner.  Verification of Provider Qualifications  Entity Responsible for Verification:  Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Frequency of Verification:	, experience or education, other The county contracted ed, trained and reliable. Service ed in a safe and effective

Nursing Facilities
Provider Qualifications License (specify):
Nursing facilities licensed under lowa Code chapter 135C and an enrolled Medicaid provider as described in IAC
441 Chapter 81.
Certificate (specify):
Other Standard (specify):
j
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services. Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
•
Service Type: Other Service Service Name: Transportation
Provider Category:  Agency
Provider Type:
Provider Contracting with NEMT
Provider Qualifications
License (specify):
¥
Certificate (specify):
Other Standard (specify):
Transportation providers contracting with the nonemergency medical transportation (NEMT) contractor. For this
service the department does not have specific standards for subcontracts or providers regarding training, age
limitations, experience or education, other than what would be contained in statute or administrative rules for this
provider. The NEMT contractor agencies are responsible to ensure that the contractor is qualified, trained and
reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.
Verification of Provider Qualifications
Entity Responsible for Verification:
Iowa Department of Human Services, the Iowa Medicaid Enterprise, Provider Services Unit
Frequency of Verification:
Every four years
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
C-1/C-3. I tovider specifications for service
Service Type: Other Service
Service Name: Transportation
Provider Category:
Agency V
Provider Type:
Regional Transit Agencies
Provider Qualifications
License (specify):

	,#2 ¹
	¥.
Certificate (specify):	
	*
Other Standard (specify):	
Regional Transit Agencies as recognized by the Iowa Department of Transportation. These agencies multiply with the Code of Federal Regulations pertaining to public transit;  2) demonstrate that vehicles used comply with public transit regulations surrounding acceptable mileage thresholds and maintenance schedules;  3) ensure that drivers must possess commercial driver's license;  4) ensure that employees pass routine drug and alcohol testing.	
All individuals providing transportation must possess the following qualifications: 1) Hold an active commercial driver's license(Iowa Code 321.88). 2) Routinely pass drug and alcohol testing. 3) Undergo training consistent with the policies of the Office of Public Transit.	
Verification of Provider Qualifications	
Entity Responsible for Verification: lowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit Frequency of Verification:	
Every four years	
Appendix C: Participant Services	
C-1/C-3: Provider Specifications for Service	
Service Type: Other Service	
Service Name: Transportation	
Provider Category:	
Agency ✓:	
Provider Type:	
HCBS Provider Agencies	
Provider Qualifications License (specify):	
Diversity 199	JF (V
	W-
Certificate (specify): Certified or accredited enrolled home and community based service (HCBS) providers under 441 IAC 24 Other Standard (specify):	
For this service the department does not have specific standards for subcontracts or providers regarding tage limitations, experience or education, other than what would be contained in statute or administrative this provider. Providers are responsible to ensure that the contractor is qualified, trained and reliable. So workers are responsible to monitor service provision to ensure services are provided in a safe and effection manner.	rules for ervice
Verification of Provider Qualifications  Entity Responsible for Verification:  The Iowa Department of Human Services, the Iowa Medicaid Enterprise, Provider Services Unit  Frequency of Verification:	
Every four years	
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Appendix C: Participant Services	
C-1/C-3: Provider Specifications for Service	
Service Type: Other Service	······································
Service Name: Transportation	
Provider Category:	
Agency	
Provider Type: Community Action Agencies	
Community and in the contract of the contract	

As an administrative activity. Complete item C-1-c.

	Provider Qualifications
	License (specify):
	Certificate (specify):
	Other Standard (specify): Community action agencies as designated in Iowa Code section 216A.93
,	Verification of Provider Qualifications
	Entity Responsible for Verification: lowa Department of Human Services, Iowa Medicaid Enterprise. Provider Services Unit
	Frequency of Verification:
	Every four years
) [) (	endix C: Participant Services
)p(	endix C: Participant Services C-1: Summary of Services Covered (2 of 2)
eelisees	
en e	C-1: Summary of Services Covered (2 of 2)  Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):
en in de la company	C-1: Summary of Services Covered (2 of 2)  Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver
en e	C-1: Summary of Services Covered (2 of 2)  Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):  Not applicable - Case management is not furnished as a distinct activity to waiver participants.  Applicable - Case management is furnished as a distinct activity to waiver participants.
anne e	C-1: Summary of Services Covered (2 of 2)  Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):  Not applicable - Case management is not furnished as a distinct activity to waiver participants.  Applicable - Case management is furnished as a distinct activity to waiver participants.  Check each that applies:

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

FFS

Case managers or integrated health home coordinators provide case management services for members enrolled in the State's §1915 (c) PD waiver. Services are reimbursed through an administrative function of DHS.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned.

MCO

MCO community-based case managers provide case management services to all members receiving HCBS. MCOs ensure ease of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

MCO community-based case managers or integrated health home care coordinators provide case management services to all members receiving HCBS. MCOs ensure case of access and responsiveness for each member to their community-based case manager during regular business hours and, at a minimum, the community-based case manager or integrated health home care coordinator contacts members at least monthly, either in person or by phone, with an interval of at least fourteen calendar days between contacts.

All individuals providing case management services have knowledge of community alternatives for the target populations and the full range of long-term care resources, as well as specialized knowledge of the conditions and functional limitations of the target populations served, and of the individual members to whom they are assigned. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements. DHS approves and monitors all MCO policies and procedures to ensure compliance.

### Appendix C: Participant Services

#### C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
  - No. Criminal history and/or background investigations are not required.
  - Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant:

- 1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
- 2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

lowa Code 249A.29 provides the scope of the above provider background screening:

- 1. For purposes of this section and section 249A.30 unless the context otherwise requires:
- a. "Consumer" means an individual approved by the department to receive services under a waiver.
- b. "Provider" means an agency certified by the department to provide services under a waiver.
- c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
- 2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department (Department of Human Services) shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
- 3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
- 4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the criminal background checks. The provider agency is responsible for completing the required waiver to perform the criminal background check and submitting to the Department of Public Safety who conducts the check. The data and other information developed by the provider in the areas of discovery, remediation, and improvement of criminal background checks are available to the Department upon request. The IME will assure that criminal background checks have been completed through quality improvement activities on a random sampling of providers, focused onsite reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. Background checks only include lowa unless the applicant is a resident of another state providing services in Iowa.

MCOs are contractually required to assure that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the MCO, are properly licensed, certified, or accredited as required under applicable state law and the lowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the lowa Administrative Code.

- b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):
  - No. The State does not conduct abuse registry screening.
  - Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a member:

- 1. An employee of a homemaker-home health aide, home care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers; and
- 2. An employee who provides direct services to consumers under a federal home and community-based services waiver.

Iowa Code 249A.29 provides the scope of the above provider background screening:

- 1. For purposes of this section and section 249A.30 unless the context otherwise requires:
- a. "Consumer" means an individual approved by the department to receive services under a waiver.
- b. "Provider" means an agency certified by the department to provide services under a waiver.
- c. "Waiver" means a home and community-based services waiver approved by the federal government and implemented under the medical assistance program.
- 2. If a person is being considered by a provider for employment involving direct responsibility for a consumer (individual approved by the department to receive services under a waiver) or with access to a consumer when the consumer is alone, and if the person has been convicted of a crime or has a record of founded child or dependent adult abuse, the department shall perform an evaluation to determine whether the crime or founded abuse warrants prohibition of employment by the provider. The department shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states. The records checks and evaluations required by this section shall be performed in accordance with procedures adopted for this purpose by the department.
- 3. If the department determines that a person employed by a provider has committed a crime or has a record of founded abuse, the department shall perform an evaluation to determine whether prohibition of the person's employment is warranted. In an evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded abuse again, and the number of crimes or founded abuses committed by the person involved. The department may permit a person who is evaluated to be employed or to continue to be employed by the provider if the person complies with the department's conditions relating to the employment, which may include completion of additional training.
- 4. If the department determines that the person has committed a crime or has a record of founded abuse that warrants prohibition of employment, the person shall not be employed by a provider.

Individual Consumer Directed Attendant Care (CDAC) is the only service that allows individuals to be providers. All others services must be provided by agency providers. Individual CDAC providers have child and dependent adult abuse background checks completed by the IME Provider Services prior to enrollment as a Medicaid provider.

All employees that provide direct services under the Consumer Choices Option under this waiver are required to complete child and dependent adult abuse background checks prior to employment with a member. The Fiscal Management provider completes the child and dependent adult abuse background checks and the employee will not pay for any services to the member prior to the completion of the checks.

The Iowa Department of Human Services maintains the Central Abuse Registry. All child and dependent adult abuse checks are conducted by the DHS unit responsible for the intake, investigation, and finding of child and dependent adult abuse. The provider agency is responsible for completing the required abuse screening form and submitting it to DHS to conduct the screening. Providers are required to complete the child and dependent adult abuse background checks of all staff that provides direct services to waiver members prior to employment. Providers are required to have written policies and procedures for the screening of personnel for child and dependent adult abuse checks prior to employment. As part of the provider's self-assessment process, they are required to have a quality improvement process in place to monitor their compliance with the child and dependent adult abuse checks are available to the Department upon request. The Department will assure that the child and dependent adult abuse checks have been completed through the Department's quality improvement activities of random sampling of providers, focused onsite reviews, initial certification and periodic reviews and during the full on-site reviews conducted every 5 years.

The State HCBS Quality Assurance and Technical Assistance Unit reviews agency personnel records during provider site visits

to ensure screenings have been completed. Screenings are rerun anytime there is a complaint related to additional criminal charges against a provider, and the Program Integrity Unit runs all individual providers against a Department of Corrections file on a quarterly basis. DHS also completes any evaluation needed for screenings returned with records or charges. MCOs are also required to ensure that all required screening is conducted for providers who are not employees of a provider agency or licensed/accredited by a board that conducts background checks (i.e., non-agency affiliated self-direction service providers). DHS retains final authority to determine if an employee may work in a particular program.

### Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:
  - No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
  - Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

### Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. Select one:
  - No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
  - Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.* 

A person who is legally responsible for a member may provide services to a member on the waiver. This applies to guardians of their adult children and not to a minor child. The person who is legally responsible for a member may be a Consumer Directed Attendant Care provider or an employee under the Consumer Choices Option program. Only Consumer Directed Attendant Care Providers and CCO Employees can be legal representatives of the member receiving CDAC or CCO self—directed personal care. When the legal representative is responsible for a member and is the CDAC or CCO provider, the DHS CM or MCO CBCM and interdisciplinary team determine the need for and the types of activities provided by legal representative. In many situations, the Medicaid member requests the guardian to provide services, as the guardian knows the member and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service. The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's plan of care that is authorized and monitored by the member's case manager.

A person who is legally responsible for a participant may provide services to a waiver participant. This applies to guardians of their adult children and not to a minor child. The person who is legally responsible for a participant may be a Consumer Directed Attendant Care (CDAC) provider or an employee under the Consumer Choices Option (CCO) program. There are no limitations on the types of services provided; however, when the legally responsible person is the CDAC or CCO provider, the service planning team determines the need for and the types of activities to be provided by the legally responsible person. This includes reviewing if the needed services are "extraordinary." Any services which are activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and are not necessary to assure the health and welfare of the participant and to avoid institutionalization would not be considered extraordinary. If the legal representative is an employee through CDAC or CCO, the relative or legal guardian must have the skills needed to provide the services to the participant. In many situations, the participant requests the guardian to provide services, as the guardian knows the participant and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

Through the person-centered planning process, the comprehensive service plan is developed. If the participant has a guardian or attorney in fact under a durable power of attorney for health care who is also their service provider, the care plan will address how the DHS TCM or MCO CBCM, health home coordinator, or community-based case manager will oversee the service provision to ensure care is delivered in the best interest of the participant.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the participant's plan of care that is authorized and monitored by a DHS TCM/MCO CBCM/health home coordinator/community-based case manager. Service plans are monitored to assure that authorized services are received. For fee-for-service participants, the State completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers. In addition, information on paid claims for fee-for-service participants are available in ISIS for review. The ISIS system compares the submitted claims to the services authorized in the plan of care prior to payment. The claim will not be paid if there is a discrepancy between the amount billed and the rate of pay authorized in the plan. MCOs are responsible for ensuring the provision of services by a legally responsible individual is in the best interest of the member and that payments are made only for services rendered. All representatives must participate in a training program prior to assuming self-direction, and MCOs provide ongoing training upon request and/or if it is determined a representative needs additional training. MCOs monitor the quality of service delivery and the health, safety and welfare of members participating in self-direction, including implementation of the back-up plan. If problems are identified, a selfassessment is completed to determine what additional supports, if any, could be made available. MCOs must ensure payments are made only for services rendered through the development and implementation of a contractually required program integrity plan. The DHS maintains oversight of the MCO program integrity plans and responsibility for overall quality monitoring and oversight.

Per to 441 Iowa Administrative Code 79.9(7):

- "a. Except as provided in paragraph 79.9(7)'b,' medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.
- b. Notwithstanding paragraph 79.9(7) a, medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger."

- Self-directed
- .... Agency-operated
- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:
  - The State does not make payment to relatives/legal guardians for furnishing waiver services.
  - The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

A member's relative or legal guardian may provide services to a member. Payments may be made to any relative who is not the parent of a minor child, a spouse, or a legal representative of the member. Legal representative means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger. The relative or legal guardian may be an Individual CDAC provider, a participant under the CCO program, or an employee hired by a provider agency. There are no limitations on the types of services provided, however, when the relative or legal guardian is the CDAC or CCO provider, the case manager, health home coordinator, or community-based case manager, and interdisciplinary team determine the need for and the types of activities provided by the relative or legal guardian. If the relative or legal guardian is an employee of a provider agency, it is the responsibility of the provider to assure the relative or legal guardian has the skills needed to provide the services to the member.

Whenever a legal representative acts as a provider of consumer-directed attendant care, the following shall apply:

- 1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
- 2. The legal representative may not be paid for more than 40 hours of service per week; and
- 3. A contingency plan must be established in the participant's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event. In many situations, the participant requests the guardian provide services, as the guardian knows the participant and their needs best. In other circumstances, there are no other qualified providers available when the service is needed or a lack of staff in the area to provide the service.

The rate of pay and the care provided by the legally responsible person is identified and authorized in the member's service plan that is authorized and monitored by the member's case manager, health home coordinator, or community-based case manager.

DHS TCM, health home coordinators, and community-based case managers are responsible to monitor service plans and assure the services authorized in the member's plan are received. In addition, information on paid claims of fee-for-service members is available in ISIS for review. The ISIS System compares the submitted claim to the services authorized in the service plan prior to payment. The claim will not be paid if there is a discrepancy between the amount billed or the rate of pay authorized in the plan. The state also completes post utilization audits on waiver providers verifying that services rendered match the service plan and claim process. This applies to individual CDAC providers and provider agencies. MCOs are required to adhere to all state policies, procedures and regulations regarding payment to legal guardians, as outlined in this section.

Per to 441 Iowa Administrative Code 79.9(7):

"a. Except as provided in paragraph 79.9(7)'b,' medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7) a,' medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013.

For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger."

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

	pt.
Other policy.	
Specify:	

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website or by calling the provider services' phone number. The IME Provider Services Unit must respond in writing within five working days once a provider enrollment application is received, and must either accept the enrollment application and approve the provider as a Medicaid provider or request more information. In addition, waiver quality assurance staff and waiver program managers, as well as county and State service workers, case mangers, health home coordinators, market to qualified providers to enroll in Medicaid.

MCOs are responsible for oversight of their provider networks. For the first two years of an MCO contract, the entity must give all 1915(c) HCBS waiver providers, which are currently enrolled as Iowa Medicaid providers, the opportunity to be part of its provider network. During this time period, the MCO may recommend disenrollment of providers not meeting defined performance measures. The State retains authority for development of the performance standards, and for review and approval of any disenrollment recommendations.

After the 2-year initial period of the MCO contract, the State ensures that LTSS providers are given the opportunity for continued participation in the managed care networks by regularly monitoring the managed care organization provider network and evaluating rationales for not having providers in their networks. While the number of providers not contracted with all three managed care organizations is small, the rationale includes providers not accepting the "floor" rates determined by the State and wanting enhanced rates. The State additionally tracks on provider inquiries and complaints which includes complaints related to network access and credentialing.

### Appendix C: Participant Services

### Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

#### i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

QP-a1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data Frequency of data Sampling Approach(check collection/generation(check collection/generation(check each that applies): each that applies): each that applies). State Medicaid Agency Weekly 100% Review Less than 100% Operating Agency Monthly Review Sub-State Entity Quarterly Representative Sample Confidence Interval Other Annually Stratified Specify: Describe Group: Contracted Entity including MCO Other

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c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
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Operating Agency	Monthly
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and reenrollment.

All MCO providers must be enrolled as verified by IME Provider Services.

The Home and Community Based Services (HCBS) quality oversight unit is responsible for reviewing provider records at a 100% level over a three to five year cycle, depending on certification or accreditation. If it is discovered that providers are

not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated if noncompliance persists.

#### b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or reenrollment approval. Until the provider make these corrections, they are ineligible to provide services to waiver members. All MCO providers must be enrolled as verified by IME Provider Services, so if the provider is no longer enrolled by the IME then that provider is no longer eligible to enroll with an MCO.

If it is discovered during HCBS Quality Oversight Unit review that providers are not adhering to provider training requirements, a corrective action plan is implemented. If corrective action attempts do not correct noncompliance, the provider is sanctioned for noncompliance and eventually disenrolled or terminated is noncompliance persists.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and required changes in individual provider policy.

ii. Remediation Data Aggregation

	Remediation-related Data Aggregation and Analyst Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):	
		Weekly	
	Operating Agency	Monthly	
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discove No.	the State does not have all elements of the Quality Impery and remediation related to the assurance of Qualificones	provement Strategy in place, provide timelines to design me led Providers that are currently non-operational.  Providers, the specific timeline for implementing identifie	
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### Appendix C: Participant Services

Appendix

### C-4: Additional Limits on Amount of Waiver Services

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

- a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (select one).
  - Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

in h amo peri fact	en a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including istorical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine but of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the od; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other ors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a icipant's needs; (f) how participants are notified of the amount of the limit. (check each that applies)
1,2297	Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized
	or more sets of services offered under the waiver.
	Furnish the information specified above.
	Furnish the information specified above.
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čas V.,	Furnish the information specified above.  Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned
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Zers S.,	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned
See S.,	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned funding levels that are limits on the maximum dollar amount of waiver services.
Amerika Amerika	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned funding levels that are limits on the maximum dollar amount of waiver services.  Furnish the information specified above.
2-15, Audit A1	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned funding levels that are limits on the maximum dollar amount of waiver services.
Augusti.	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned funding levels that are limits on the maximum dollar amount of waiver services.  Furnish the information specified above.
Authorities and Authorities an	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned funding levels that are limits on the maximum dollar amount of waiver services.  Furnish the information specified above.  Other Type of Limit. The State employs another type of limit.

### Appendix C: Participant Services

#### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4) -(5) and associated CMS guidance. Include:

- 1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
- 2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, <u>HCB Settings Waiver Transition Plan</u> for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Detailed information and timelines for the HCBS Settings project are included in Attachment #2 HCB Settings. The Iowa Medicaid Enterprise received initial CMS approval for Iowa's statewide HCBS transition plan on August 10, 2016.

# Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

	cipant-Centered Service Plan Title: Service Plan
	ponsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the elopment of the service plan and the qualifications of these individuals (select each that applies):  Registered nurse, licensed to practice in the State
	Licensed practical or vocational nurse, acting within the scope of practice under State law
1.00000	Licensed physician (M.D. or D.O)
	Case Manager (qualifications specified in Appendix C-1/C-3)
	Case Manager (qualifications not specified in Appendix C-1/C-3).
100 1000	Specify qualifications:
	In 2017 the IME transitioned service planning responsibilities for FFS members from DHS Service Workers to the entity DHS Targeted Cases Management. DSH TCM is an arm of the DHS Mental Health and Disability Services. DHS TCM is CARF certified for case management. DHS targeted case managers (TCM) must be licensed social workers. The case managers develop service plans for fee-for-service members.
	Qualifications include: graduation from an accredited four-year college or university; or the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.
	In addition, DHS TCMs may be required to have the following specified experience in the following areas if they are specifically working with these populations:
	- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the intellectual disability background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.  - Intellectual disability: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.
	MCO community-based case managers develop service plans for members receiving HCBS waiver services. MCOs community-based case managers are required to meet all of the qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 regarding the accreditation of providers of services to persons with mental illness, intellectual disability; and developmental disabilities.  Social Worker

Other

Specify qualifications:

Specify the individuals and their qualifications:

Integrated Health Homes, through their Care Coordinators, are responsible for service planning functions for those members enrolled with an IHH. IHH care coordinators must meet the requirements as outlined in the approved Health Home SPA Attachment H, SPMI: The Care Coordinator must be a BSW with an active license, or BS/BA in the related field.

### Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards. Select one:
  - Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
  - Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that	at service plan development is conducted in the
best interests of the participant. Specify:	

# Appendix D: Participant-Centered Planning and Service Delivery

## D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the member and an interdisciplinary team, regardless of delivery system. Teams often consist of the member and, if appropriate, their representative; case manager, health home coordinator, or community-based case manager; service providers; and other supporting persons selected by the member. During service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the member, and is intended to reflect the member's cultural considerations. If the member chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions. The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid members. Further, the Member Services Unit distributes a quarterly newsletter in effort to continually educate waiver members about services and supports that are available but may not have been identified during the service plan development process.

The IME MSU remains available to answer questions and offer support. Further, the MSU distributes a quarterly newsletter in effort to continually educate participants about services and supports that are available but may not have been identified during the service plan development process.

The interRAI Standardized Assessment Tool or other department designated standardized assessment tool is completed prior to the initiation of services and yearly thereafter for fee-for-service (FFS) and MCO members.

The fee-for-service person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the member and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b):
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:

- Include people chosen by the member;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and
- Record the alternative home and community-based settings that were considered by the member.

### Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service members service plans are developed by the member; case manager or health home coordinator; and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the individual. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition. The case manager or health home coordinator receives the assessment and level of care determination from medical services. A summary of the assessment becomes part of the service plan. The case manager or health home coordinator uses information gathered from the assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed.

Note: The assessments are identified in Appendix B-6-e.

The case manager or health home coordinator informs the member of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with members and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME website. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

The case manager or health home coordinator will also discuss with the member the self-direction option and give

the member the option of self-directing services available. The member and the interdisciplinary team choose services and supports that meet the member's needs and preferences, which become part of the service plan. Service plans must:

- Reflect that the setting in which the individual resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the member to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her:
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

he case manager or health home coordinator will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a participant chooses to self-direct, the participant, with the help of a DHS case manager identifies who will be providing Independent Support Broker Services.

#### MCO MEMBERS

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the individual. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction.

#### Services plans must:

- Reflect that the setting in which the individual resides is chosen by the member;
- Reflect the member's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;

- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet member's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service:
- Include the identified activities to encourage the member to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the member's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the member receiving services and supports, and the individuals important in supporting him or her:
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

MCO members have appeal rights, including access to a State Fair Hearing after exhausting the MCO appeal process. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. MCOs are contractually required to implement a comprehensive strategy to ensure a seamless transition of services during program implementation. Further, MCOs are required to develop and maintain, subject to DHS approval, a strategy and timeline within which all waiver members will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive DHS prior approval.

# Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed for FFS members by a case manager or integrated health home care coordinator, and for MCO members by their respective MCO, using the assessment tools designated in B-6e. The assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the participant in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the participant or other persons or significant amounts of property damage. The service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition providers of applicable services shall provide for emergency backup staff.

Emergency plans are developed on the following basis:

- Providers must provide for emergency, back-up staff in applicable services.

- Interdisciplinary teams must identify in the service plan, as appropriate for the individual member health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.
- The team identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or the member's needs change.

Personal Emergency Response and Portable Locator Services are available under the waiver and it is encouraged that this service be used as part of emergency backup plan when a scheduled support worker does not appear. Other providers may be listed on the service plan as source of back up as well. All participants choosing the self-direction option will sign an individual risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

The IME has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. For fee-for-service members, this system assists the Medicaid Agency and the case manage and health home coordinator with tracking information, and monitoring and approving the service plan. Through ISIS, case manager or health home coordinator authorizes service and service payments on behalf of the member. There are certain points in ISIS process that require contacting the designated DHS central office personnel. The case manager and health home coordinator are responsible for the development the service plan and the service plan is authorized through ISIS, which is the Medicaid Agency. (Refer to appendix A and H for ISIS system processes.)

MCOs have processes to ensure the necessary risk assessments and mitigation plans are completed and made available to all parties.

### Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

While information about qualified and accessible providers is available to members through the IME website, MCO website, and/or MCO member services call center, the case manager, health home coordinator, community-based case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with the available providers before making a selection. Members are not restricted to choosing providers within their community. Information about qualified and accessible providers is also available to members through their case manager, health home coordinator, community-based case manager, IME website, and/or MCO website. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service. The MCO will also assist with assuring continuity of care when an innetwork provider becomes available. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs to the extent their provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24- hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

# Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service members. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME MSU conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of lowa's performance measures. The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. ISIS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

Service Plan Review and Undate The service plan is subject to at least applied periodic review and undate to assess

### Appendix D: Participant-Centered Planning and Service Delivery

## D-1: Service Plan Development (8 of 8)

	the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:
	Every three months or more frequently when necessary
	Every six months or more frequently when necessary
	Every twelve months or more frequently when necessary
	Ofher schedule
	Specify the other schedule:
i.	Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):  Medicaid agency
	Operating agency
	Case manager
	✓ Other
	Specify:
	Case managers or health home coordinators maintain fee-for-service member service plans. MCO community-

# Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

based case managers maintain MCO member service plans.

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

**FFS** 

The case managers are responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service members, including:

- Monitoring service utilization.
- Making at least one contact per month with the member, the member's legal representative, the member's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the member at least once every three months.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting member needs, the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed.

The member is encouraged during the time of the service plan development to call the case manager or health home

coordinator, if there are any problems with either Medicaid or non-Medicaid services. The case manager will then follow up to solve any problems. Monitoring service utilization includes verifying that:

- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

The HCBS specialists (of the HCBS QA Unit) monitor the how member health and welfare is safeguarded, the degree of service plan implementation; and the degree of interdisciplinary team involvement of the case manager, or health home coordinator during the HCBS Quality Assurance review. Members are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live.

HCBS specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and members are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of member service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager, CBCM, or health home coordinator. All service plans reviewed are assessed for member participation, whether the member needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

#### **MCO**

MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members and choice of service providers. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits.

MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively. If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State.

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues.

If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon

between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of \$315 per occurrence.

- b. Monitoring Safeguards. Select one:
  - Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
  - Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:* 

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### Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

- i. Sub-Assurances:
  - a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

SP-a: The IME shall measure the number and percent of service plans that accurately reflect the member's assessed needs. The assessed needs must include, at a minimum, personal goals, health risks, and safety risks. Numerator = # of service plans that address all member assessed needs including health and safety risks, and personal goals. Denominator = # of reviewed service plans.

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):

Weekly

Sampling Approach (check each that applies):

Weekly

Sampling Approach (check each that applies):

| Check each that applies | Weekly | 100% Review |

State Medicaid Agency	Posemenabliosisticiares	Control of the Contro
Operating Agency	✓ Monthly	✓ Less than 100%     Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity including MCO	Annually	Stratified  Describe  Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	
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Responsible Party for data Frequency of data aggregation and aggregation and analysis (check each analysis(check each that applies): that applies): Weekly State Medicaid Agency Operating Agency Monthly Quarterly Sub-State Entity Other Annually Specify: ÷ Continuously and Ongoing Other Specify:

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

SP-c2: The IME will measure the number and percent of service plans which are updated on or before the member's annual due date. Numerator = # of service plans updated prior to due date; Denominator = # of service plans reviewed.

Data	Source	(Select	one)	):

Record reviews, off-site

If 'Other' is selected, specify:

person-centered plans an	y: d the results of the depart:	ment approved assessmen
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	<b>₩</b> Monthly	Less than 100%  Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Medicaid contracted entity including MCO	Annually	Stratified  Describe  Group:
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Other Specify:
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#### Performance Measure:

SP-c1: The IME will measure the number and percent of service plans which were revised when warranted by a change in the member's needs. Numerator = # of service plans updated or revised when warranted by changes to the member's needs. Denominator = # of reviewed service plans.

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

person-centered plans and the results of the department approved assessment Responsible Party for Frequency of data Sampling Approach collection/generation (check each that applies): data collection/generation (check each that applies): (check each that applies): 100% Review State Medicaid Weekly Agency **Operating Agency** Monthly ✓ Less than 100% Review Representative **Sub-State Entity** Quarterly Sample Confidence Interval =

5%

₹ Other	Annually	Stratified
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Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually
Specify:	
	Continuously and Ongoing
	Other
	Specify:

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

SP-d1: The IME will measure the # and percent of members' service plans that identify all the following elements: * amount, duration, and funding sources of all

services * all services authorized in the service plan were provided as verified by supporting documentation. Numerator: # members receiving services authorized in their service plan; Denominator = # of service plans reviewed.

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify: Service plans are requested from the case managers, with service provision documentation requested from providers Frequency of data Sampling Approach Responsible Party for data collection/generation (check each that applies): collection/generation (check each that applies): (check each that applies). Weekly 100% Review State Medicaid Agency Less than 100% Operating Agency Monthly Review Representative Sub-State Entity Quarterly Sample Confidence Interval = 5% Stratified Annually Other Specify: Describe Contracted Entity Group: including MCO Continuously and Other Specify: Ongoing Other Specify: Data Aggregation and Analysis: Frequency of data aggregation and Responsible Party for data analysis(check each that applies): aggregation and analysis (check each that applies): State Medicaid Agency Weekly Monthly **Operating Agency** Quarterly Sub-State Entity Annually Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	Continuously and Ongoing
	Other
	Specify:
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e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

SP-e1: The IME will measure the number and percentage of members from the HCBS IPES who responded that they had a choice of services. Numerator = # of IPES respondents who stated that they were a part of planning their services; Denominator = # of IPES respondents that answered the question asking if they were a part of planning their services.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc) If 'Other' is selected, specify:

FS HCBS UNIT OA survey data and MCO IPES databases

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	✓ Monthly	✓ Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	₹ Quarterly
Other Specify:	Annually
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propose entre pre 1 en 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	Other Specify:

#### Performance Measure:

SP-e2: The IME will measure the number and percentage of service plans from the HCBS QA survey review that indicated the member had a choice of providers. Numerator: The total number of service plans reviewed which demonstrate choice of HCBS service providers; Denominator: The total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

FFS QA review of service plan stored in OnBase. MCO review services plans available through their system.

Responsible Party for Frequency of data Sampling Approach collection/generation (check each that applies): data (check each that applies): collection/generation (check each that applies): 100% Review State Medicaid Weekly Agency ✓ Less than 100% Monthly **Operating Agency** Review Representative **Sub-State Entity** Quarterly Sample

The second control of		Confidence Interval = 5%
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Operating Agency	Monthly
Sub-State Entity	✓ Quarterly
Other Specify:	Annually
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.

#### b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. MCOs are responsible for oversite of service plans for their members.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider training, collaboration with stakeholders and changes in policy.

## ii. Remediation Data Aggregation Remediation-related Data Aggregation and Analysis (including trend identification) Frequency of data aggregation and analysis Responsible Party(check each that applies): (check each that applies): Weekly State Medicaid Agency Monthly Operating Agency Sub-State Entity Quarterly Annually √ Other Specify: contracted entity Continuously and Ongoing Other Specify: c. Timelines When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational. No Yes Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

### Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

### Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services for members regardless of delivery (FFS members or MCO members)—the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) service. There is no difference in how the CCO and CDAC services work with the MCO and FFS members. The MCO per member/per month capitation does not affect the self-direction process; and the capitation does not affect the amount of budget available to the member.

Consumer Choices Option (CCO)

The CCO offers both employer and budget authority to the member self-directing services. At the time of service plan development and/or at the member's request, the member has the option to convert the following services into an individualized self-direction budget based on services that are authorized in their service plan: (1) consumer-directed attendant care (unskilled); (2) home and vehicle modification; (3) specialized medical equipment; and (4) transportation.

CCO gives members control over a targeted amount of waiver dollars. Under CCO a member may convert specific waiver services that have been authorized in the member's service plan to create an individual monthly budget. Members that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchase other goods and services. A member may use the following three types of self-direction services to meet their assessed needs: (1) self-directed personal care services; (2) self-directed community supports and employment; and (3) individual-directed goods and services.

If any of these options are elected, an Independent Support Broker (ISB) and Financial Management Service (FMS), by Sate administrative rule, must be involved. Two budgets will be developed as a result of the service plan development traditional services budget (includes traditional services for which the member does not have budget or employer authority) and the individual budget (includes services and supports for which the member does have budget and employer authority). Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community, as well as activities of daily living and incidental activities of daily living that help the member remain in their home and in their community. Self-directed Community Supports and Employment are services that support the member in developing and maintaining life and community

integration. Individual-directed goods and services are services, equipment or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the service plan. The item or services would decrease the need for other Medicaid services, and/or promote inclusion in the community, and/or increase the member's safety in the community or home.

Members have authority over the individual authorized budget to perform the following tasks: (1) contract with entities to provide services and support; (2) determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441 Iowa Administrative Code Chapter 79.1(2); (3) schedule the provision for services; (4) authorize payment for waiver goods and services identified in the individual budget; and (5) reallocate funds among services included in the budget. Individual monthly budget development includes the costs of the FMS, ISB, and any services and supports chosen by the member as optional service components.

All members choosing CCO will work with an ISB who will help them plan for their individual budget and services. The ISB works at the direction of the member and assists the member with their budget. For example, the ISB may help develop a monthly budget, recruit and interview potential employees, or assist with required paperwork. The ISB is required to attend an ISB training prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member, to avoid potential conflicts of interest.

Per 441 Iowa Administrative Code 78.34(13)"k," the ISB "shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member."

Members will also work with an FMS provider that will receive Medicaid funds on behalf of the member. The FMS is a Medicaid provider, and receives an electronic funds transfer (EFT) on a monthly basis for the member's monthly budget amount. The FMS is responsible for paying all employer taxes as required. Employees of the member are required to submit timecards within thirty days of providing the service for payment. The member's monthly budget includes a monthly per member, per month fee for the FMS provider, with the remainder designated for the purchase of goods and services for the participant. Per 441 lowa Administrative Code 78.34(13)"1," the FMS "shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
- 1. Verifying that hourly wages comply with federal and state labor rules.

- 2. Collecting and processing timecards.
- 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
- 4. Computing and processing other withholdings, as applicable.
- 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
- 6. Preparing and issuing employee payroll checks.
- 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
- 8. Processing federal advance earned income tax credit for eligible employees.
- 9. Refunding over-collected FICA, when appropriate.
- 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service."

A utilization adjustment factor (UAF) is used to adjust the CCO budget to reflect statewide average cost and usage of waiver services. Annually, the Department determines the average cost for each waiver service. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This percentage is applied to the cap amount to determine the CCO "budget amount". The budget amount is the total funds available to the member in the monthly CCO budget. This UAF includes all HCBS waiver members in the calculation, not just members participating in CCO.

The member may choose to set aside a certain amount of the budget each month to save towards purchasing additional goods or services they cannot buy from the normal monthly budget. A savings plan must be developed by the member, and approved by DHS prior to implementation. The good or service being saved for must be an assessed need identified in the member's service plan.

Consumer Directed Attendant Care (CDAC)

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is comprised of 2 components: CDAC-Skilled and CDAC-Unskilled. Both components offer self-directed services. CDAC-Skilled offers the member employer authority only. CDAC-Unskilled provides both the employer authority and the budget authority. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met.

# Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

	ticipant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. act one:
,64. .w.**	Participant: Employer Authority. As specified in <i>Appendix E-2</i> , <i>Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
	Participant: Budget Authority. As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.
c. Ava	nilability of Participant Direction by Type of Living Arrangement. Check each that applies:
Z	Participant direction opportunities are available to participants who live in their own private residence or
	the home of a family member.  Participant direction opportunities are available to individuals who reside in other living arrangements
	where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
seens.	The participant direction opportunities are available to persons in the following other living arrangements
	Specify these living arrangements:
	4
Append	ix E: Participant Direction of Services
420049 10 (State # 2000)	E-1: Overview (3 of 13)
d. Elec	ction of Participant Direction. Election of participant direction is subject to the following policy (select one):
	Waiver is designed to support only individuals who want to direct their services.
	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.
	Specify the criteria
	A
Append	ix E: Participant Direction of Services
Secretary Contraction of the Con	E-1: Overview (4 of 13)
e. Infe	ormation Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the

participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information

https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.jsp

is provided on a timely basis.

Self-direction training and outreach materials are available through the IME website and MCOs. Materials include information on the benefits, responsibilities, and liabilities of self-direction. A brochure about this option has been developed and includes information about the benefits, responsibilities, and liabilities. This brochure is available at all the local DHS offices, the DHS website, and has been distributed to other community agencies. The participant may also call IME Member Services and request to have the brochure mailed directly to them. All members must sign an informed consent contract and a risk agreement that permits the member to acknowledge and accept certain responsibilities for addressing risks.

The case manager, health home coordinator, or community-based case manager is required to discuss this option along with the benefits, responsibilities and liabilities at the time of the service plan development and/or any time the member's needs change. This results in information about member direction activities being reviewed, at least annually, with the member. This option is intended to be very flexible; members can choose this option at any time. Once given information about this option, the member can immediately elect this option, or can elect to continue or start with traditional services initially and then change to self-direction at a later date.

MCOs must also provide ongoing member or representative training upon request and/or if it is determined a member needs additional training. Training programs are designed to address the following: (i) understanding the role of members and/or representatives in self-direction; (ii) selecting and terminating providers; (iii) being an employer and managing employees; (iv) conducting administrative tasks such as staff evaluations and approval of time sheets; (v) scheduling providers; and (vi) back-up planning. All MCO training and education materials are subject to review and approval by the State.

To give the member an opportunity to locate providers and supports, the service plan can reflect that traditional services will begin at the start date of the service plan and the self-directed services and supports will begin at a later date. This does not require a change in the service plan. Members can elect self-direction and then elect to go back to traditional services at any time. The case manager, health home coordinator, or community-based case manager is responsible for informing the member of their rights and responsibilities. All self-directed services and supports must begin on the first of a month.

## Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (select one):
  - The State does not provide for the direction of waiver services by a representative.
  - The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (check each that applies):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Services may be self-directed by a non-legal representative freely chosen by an adult member. The policies described in this section apply to both the fee-for-service and managed care delivery systems. If the member selects a non-legal representative, the representative cannot be a paid provider of services and must be eighteen years or age or older. The member and the representative must sign a consent form designating who they have chosen as their representative and what responsibilities the representative will have. The choice must be documented in the member's file and provided to the member and their representative. At a minimum, the representative's responsibilities include ensuring decisions made do not jeopardize the health and welfare of the member and ensuring decisions made do not financially exploit the member.

The IME uses a quality assurance process to interview members in order to determine whether or not the

representative has been working in their best interest. The interviews are completed primarily by telephone and may be completed in-person if requested. The interviews are conducted as an ongoing QA activity and are used to ensure that members' needs are met and that services are provided. QA interviews are completed monthly with a randomly selected representative sample of members. The interview sample selection size assures a 95% confidence level in the results of the interviews.

In addition, the Independent Support Broker provides monitoring of health and safety. The member's case manager, CBCM, or health home coordinator is responsible to assess individual needs and monitor service delivery to assure that the member's health and safety are being addressed. Case managers, CBCMs, and health home coordinators routinely review how services are being provided and monitor services to assure the member's needs are being met, including how the representative is performing.

MCOs are contractually required to maintain quality assurance processes to ensure that the representative functions in the best interest of the member. These quality assurance processes are subject to DHS review and approval and include, but are not limited to, monthly member interviews, to assess whether a non-legal representative is working in the best interest of the member. DHS provides additional oversight in accordance with the HCBS quality improvement strategy.

## Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services	Z.	×.
Transportation	2	<del>V</del>
Specialized Medical Equipment		
Home and Vehicle Modification	× .	×.
Consumer-Directed Attendant Care (Skilled)	¥.	
Self Directed Personal Care		V
Consumer-Directed Attendant Care (Unskilled)		Z
Self-directed Community Support and Employment	4	<b>₹</b>
Independent Support Broker	\$	Z

# Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one:
  - Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or	r private	entities	furnish	these service	s. Check e	ach that	applies
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:	Governmental entities
1	Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

## Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. Select one:
  - FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled: Financial Management Service

FMS are provided as an administrative activity.

#### Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Entities providing FMS must be cooperative, not-for-profit member owned and controlled, federally insured financial institution that is and charged by either the National Credit Union Administration or the Credit Union Division of the Iowa Department of Commerce. The FMS must successfully pass a readiness review of certification by DHS or a financial institution charted by the Office if the Comptroller of the Currency, a Bureau of the United States Department of the Treasury, is a member of the Federal Reserve; and/or is federally insured by the Federal Deposit Corporation. Further, the entity must be enrolled as a Medicaid provider. Once enrolled and approved as a Medicaid provider, the FMS will receive Medicaid funds in an electronic transfer and will pay all service providers and employees electing the self-direction option.

MCOs are responsible for contracting with an FMS entity or entities to assist members who elect to self-direct. All MCO contracted FMS entities must meet the requirements documented in this section. Under the managed care delivery system, the FMS entity contracted with the MCO is responsible for the same functions as under the fee-for-service model.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS is paid a monthly fee for their services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (check each that applies):

ipports furnished when the participant is the employer of direct support workers:
Assist participant in verifying support worker citizenship status
Collect and process timesheets of support workers
Process payroll, withholding, filing and payment of applicable federal, state and local
employment-related taxes and insurance
Other Control of the
Specify:
Į
apports furnished when the participant exercises budget authority:
Maintain a separate account for each participant's participant-directed budget
Track and report participant funds, disbursements and the balance of participant funds
Process and pay invoices for goods and services approved in the service plan
Provide participant with periodic reports of expenditures and the status of the participant-
directed budget
Other services and supports

	Specify:	
Add	litional functions/activities:	
~	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget Other	
	Specify:	
		ر چھر
		Ψ.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

IME provides oversight of the FMS entities and monitors their performance yearly. Oversight is conducted through an annual self-assessment, and an on-site review completed by DHS or by a designated IME unit. As noted above, FMS entities must also be enrolled as Medicaid providers. The MCOs are required to mirror this oversight process for their FMS entities and the IME reviews for compliance and monitors outcomes.

## Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):
  - Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager, health home coordinator, or community-based case manager provides the waiver member with information and assistance with choosing the CCO program or CDAC service as part of the person centered service planning process. The case manager, health home coordinator, or community-based case manager also assists the member in locating an Individual Support Broker to assist with the planning and managing a monthly CCO budget and is responsible for monitoring the delivery of goods and services as identified in the service plan.

The CCO program conducts regular CCO webinars to provide case managers, health home coordinators, community-based case managers, and ISB's with information on understanding and implementing the CCO program. The webinars also identify self-direction issues that have been identified through quality assurance activities. All case managers, health home coordinators, and community-based case managers are welcome to attend the webinars, which are also recorded and made available for those unable to attend.

The CDAC service began in Iowa in 1996 and was the first attempt by the State to offer self-directed services. CDAC is a self-directed service that offers the member employer authority only. There are two CDAC services—skilled and unskilled. See Appendix C for service description and provider qualifications. All CDAC providers are enrolled Medicaid providers, and may be an individual employee or an agency. There are no FMS or ISB services to support the CDAC service, and the enrolled CDAC provider performs all billing through the Medicaid MMIS systems. The member is responsible for completing the CDAC agreement with the CDAC provider. The CDAC agreement identifies the personal care services that will be performed. The member is responsible for hiring, directing, and supervising the CDAC provider to assure their identified needs are being met.

Waiver Service Coverage. Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	
Financial Management Services	The state of the s
Personal Emergency Response	
Transportation	-10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.000 -10.00
Specialized Medical Equipment	дерия ; 340344 ²
Home and Vehicle Modification	
Consumer-Directed Attendant Care (Skilled)	
Sell Directed Personal Care	
Coasumer-Directed Attendant Care (Unskilled)	
Self-directed Community Support and Employme	ent Z
Independent Support Broker	X.

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Through a contract with the Iowa Medicaid Enterprise (IME) the HCBS Quality Assurance and Technical Assistance Unit provides support and assistance to case managers, health home coordinators, community-based case managers, members, providers, ISBs, and others needing information about HCBS waiver programs. This includes the self-direction program. The technical assistance provided includes developing and conducting regularly scheduled webinar trainings, developing and implementing required ISB training and answering questions from the field about the CCO program.

The Quality Assurance and Technical Assistance contract is procured through a competitive bidding process. A request for proposal is issued every three years to solicit bids. The RFP specifies the scope of work to be completed by the contractor. The RFP process also includes a pricing component to assure that the contractor is reimbursed in an amount that assures performance outcomes are achieved in a cost effective manner.

The Quality Assurance and Technical Assistance contract is managed by an IME state employee. This employee acts as the contract manager and manages the day-to-day operations of the contract to assure compliance with the performance outcomes of the contract. Contract reports are received by the IME monthly, quarterly and annually on the performance measures of the contract. Any performance issues that arise are addressed with the Quality Assurance and Technical Assistance Unit contract manager to make corrections and improve performance.

# Appendix E: Participant Direction of Services

#### E-1: Overview (10 of 13)

- k. Independent Advocacy (select one).
  - No. Arrangements bave not been made for independent advocacy.
  - Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

	r ⁱ
	- 4

### Appendix E: Participant Direction of Services

#### E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Members may receive traditional waiver services, as well as services and supports under an individual budget for self-direction. Any waiver member may voluntarily discontinue the self-direction option at any time, regardless of delivery system (FFS members or MCO members). The member will continue to be eligible for services as specified in the service plan, regardless of whether they select the self-direction option. A new service plan will be developed if the member's needs change or if they voluntarily discontinue the self-direction option. The case manager, health home coordinator, or community-based case manager will work with the member to ensure that services are in place and that service continuity is maintained.

## Appendix E: Participant Direction of Services

#### E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

For fee-for-service enrollees, case managers or health home coordinators will terminate use of the self-direction option any time there is substantial evidence of Medicaid fraud or obvious misuse of funds. Involuntary termination can also occur if the case manager or health home coordinator is not able to verify the types of services provided and the outcome of those services. If the member and their representative are both found unable to self-direct, the member will be transitioned to regular waiver services. The member has the right to appeal any adverse action taken by the case manager or health home coordinator to terminate self-directed services and is subject to the grievance and appeals protections outlined in Appendix F. The case manager or health home coordinator will develop a new service plan and assure alternative services are in place to maintain service.

MCOs may only initiate involuntarily termination of a member's use of the self-direction option if there is evidence of Medicaid fraud or misuse of funds, or if the MCO determines there is a risk to the member's health or safety. Under these conditions, MCOs are required to submit a request to DHS for review and approval to involuntarily terminate. Requests must contain sufficient documentation regarding the rationale for termination. Upon DHS approval, MCOs must notify the member and facilitate a seamless transition to traditional waiver services to ensure there are no interruptions or gaps in service delivery.

## Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		69
Year 2		79
Year 3		91
Year 4	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	105
Year 5		121

## Appendix E: Participant Direction of Services

#### E-2: Opportunities for Participant Direction (1 of 6)

a.	$\textbf{Participant-Employer Authority} \ \textit{Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:}$
	i. Participant Employer Status. Specify the participant's employer status under the waiver. Select one or both:
	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-
	employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources
	functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

V	Participant/Common Law Employer. The participant (or the participant's representative) is the
	common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer
	Agent functions as the participant's agent in performing payroll and other employer responsibilities that
	are required by federal and state law. Supports are available to assist the participant in conducting
	employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Select one or more decision making authorities that participants exercise:

1	Recruit staff
****	Refer staff to agency for hiring (co-employer)
	Select staff from worker registry
<b>V</b>	Hire staff common law employer
	Verify staff qualifications
- Arri	Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

	waiver services must complete child abuse, dependent adult abuse and criminal background screenings before employment of a prospective staff member who will provide care for a participant. The State pays for the first background check of workers who provide waiver services to fee-for-service participants. If a second background check is completed, it is the responsibility of the employee to pay for the background check. MCOs are responsible for the costs of investigations of workers who provide
	waiver services to members.  Specify additional staff qualifications based on participant needs and preferences so long as such
V0000000	qualifications are consistent with the qualifications specified in Appendix C-1/C-3.  Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
e e e e e e e e e e e e e e e e e e e	Determine staff wages and benefits subject to State limits
wait w	Schedule staff
	Orient and instruct staff in duties
7	Supervise staff
ATTT	Evaluate staff performance
ACRESCO"	Verify time worked by staff and approve time sheets
· production	Discharge staff (common law employer)
energia (	Discharge staff from providing services (co-employer)
VV0002-19	Other
samo	
	Specify:
ppendix E: l	Participant Direction of Services
E-2:	Opportunities for Participant-Direction (2 of 6)
b. Participant Item E-1-b:	t - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in
	ticipant Decision Making Authority. When the participant has budget authority, indicate the decisioning authority that the participant may exercise over the budget. Select one or more:
	Reallocate funds among services included in the budget
	Determine the amount paid for services within the State's established limits
	Substitute service providers
~	Schedule the provision of services
	Specify additional service provider qualifications consistent with the qualifications specified in
permanent.	Appendix C-1/C-3
<b></b>	Specify how services are provided, consistent with the service specifications contained in Appendix
	C-1/C-3
. Z	Identify service providers and refer for provider enrollment
4	Authorize payment for waiver goods and services
· ·	Review and approve provider invoices for services rendered
1	Other
	Specify:
	. Y
mandie F.	Participant Direction of Services
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Pursuant to Iowa Code 249A.29 and Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), all providers of HCBS

## E-2: Opportunities for Participant-Direction (3 of 6)

#### b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Under the traditional service model for the waiver, the member chooses a service provider from a list of providers who are enrolled with Iowa Medicaid. The case manager or health home coordinator and member work together to detail the tasks and goals for the provider. After service provision, the provider submits a claim to the IME where the claim is adjudicated in accordance with IME protocols.

Under the self-direction option, a member is not limited to the providers who have enrolled with Iowa Medicaid. The member is considered the employer and can choose any individual that they feel is qualified to provide the needed service. Members create support plans, make provider and service choices, select and employ staff, and monitor the quality of support services. MCOs are responsible for assisting the member with quality assurance activities and monitoring the quality of services provided. MCO plans to accomplish this contractual requirement are subject to DHS review and approval. Members determine the wages to be paid to the provider and the units of service (limited by the self-direction budget). Interviewing, hiring, scheduling, and firing is done by the member. Claims are submitted to the FMS for processing for payment.

Each member who chooses to self-direct their services will continue to have a traditional service plan developed that is based on the level of care assessment and need of the member. If a member has a need for the services that can be included in the individual budget and they choose to self-direct one or all of those services, then the individual budget amount is determined by the amount of service that was authorized for those services under the traditional service plan. The level of need is determined by the level of care determination made by IME MSU; the supports needed and the amount of supports needed are determined by a review of the assessment made by the case manager, CBCM, or health home coordinator prior to the member selecting the self-direction option. Members who reside in an assisted living facility may also choose to self-direct some of their services. Specifically, the member can choose to self-direct services not provided by the facility (i.e., vehicle modification) or can choose another provider for services that are optional from the facility (i.e., meals or housekeeping).

Historically, members do not use 100% of their authorized waiver services. To ensure that the State or MCO does not spend more than what is historically spent for traditional waiver services, each service authorized under self-direction will have a utilization adjustment factor applied to it. This utilization adjustment factor is determined by an analysis of what percentage of authorized services has historically been used for each service on an aggregate by all members enrolled in that particular waiver who have accessed that particular service. The utilization factor is not based upon individual member usage, but on historical percentage usage of authorized services by all members enrolled in the waiver who have accessed that particular service. A member new to the waiver or new to self-direction would have the same utilization factor applied as all other waiver members who are self-directing services. The utilization adjustment factor will be analyzed, at a minimum, every 12 months and adjusted as needed based historical use. This method will be used for all waiver members choosing the self-direction option. Members are notified of the budget methodology and limits at the time they receive the CCO Booklet, during their service plan is development and by the Independent Support Broker hired to assist the individual to develop the budget. The individual budget methodology is stated in the 441 Iowa Administrative Code Chapter 78.41(15). In addition, this information is shared during all outreach and training held throughout the State for members, families, and other advocates. The MCOs are also responsible for making the budget methodology available to members through their case managers and member communication materials.

The following is an example of how an individual budget is determined:

A member has a need for a particular service. On their traditional service plan they are authorized 10 units of service at \$20 a unit. That member decides that they would like to self-direct their services. The amount authorized is \$200 in the traditional service plan. A utilization adjustment factor of 80% is applied. The member's individual budget amount then becomes \$160 (\$200 X 80%). The 20% reduction (100%)

authorization minus 80% actual utilization for a service) is applied to allow for cost neutrality between the service under the traditional waiver plan and self-direction. If the average service utilization is only 80% of an authorized service under the traditional waiver, then a self-directed member is limited to that same 80% to preserve cost neutrality. The total monthly cost of all services (traditional and self-directed services) cannot exceed the established aggregate monthly cost of the traditional services authorized.

If there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy. Exceptions to policy may be granted to the requestor when the member has needs beyond the limits expressed in the Iowa Administrative Code. For fee-for-service members this decision is made by the Director of DHS, based on an evaluation of the member's needs in relation to the State's necessity to remain within the waiver's parameters of cost neutrality. The process to request an exception is shared on the DHS website as well as with the member when they apply for waiver services. In addition, any member has the right to appeal any decision made by DHS and to request an appeal hearing by an administrative law judge. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

The MCOs operate an exception to policy process for their members. In the event an MCO denies an exception to policy and determines the member can no longer have his or her needs safely met through the 1915(c) waiver, the MCO is required to forward this information to DHS. In addition, MCO members have the right to appeal any decision made by the MCO and may appeal to the DHS once the MCO appeals process has been exhausted as described in F-1.

## Appendix E: Participant Direction of Services

# E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Members, regardless of delivery system (i.e., FFS members and MCO members) will be informed of their budget amount during the development of the service plan. The member can then make a final decision as to whether they want the self-direction option. If a member needs an adjustment to the budget, the member can request a review of the service plan.

As noted above, if there is a need that goes beyond the budget amount and/or the waiver service limit, the member has the right to request an exception to policy. In addition, any member has the right to appeal any decision. The member is afforded the opportunity to request a fair hearing when the budget adjustment is denied or the amount of budget is reduced as described in F-1.

MCO enrollees have the right to a State Fair Hearing after exhausting the MCO appeals process. It is the responsibility of the health home coordinator, case manager, and community based case manager to inform the member of the budget amount allowed for services before the service plan is completed.

# Appendix E: Participant Direction of Services

# E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

- iv. Participant Exercise of Budget Flexibility. Select one:
  - Modifications to the participant directed budget must be preceded by a change in the service plan.
  - The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

For both fee-for-service and MCO members, once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. This budget amount is the same amount whether the member utilizes only traditional waiver services, utilizes only self-directed services, or uses a combination of traditional and self-directed services. All services under the waiver add into the one budget and that budget maximum is determined by the member's level of care and not by the type of services accessed by the member.

Once the monthly budget amount has been established, the member will develop a detailed monthly budget that identifies the goods and services that will be purchased and the employees that will be hired to meet the assessed needs of the member. The budget is sent to the FMS to identify what goods and services are approved for purchase and the employees that will be submitting timecards to the FMS for payment. The member can modify services and adjust dollar amounts among line items in the individual budget without changing the service plan as long as it does not exceed the authorized budget amount. They must submit a new budget to the FMS that identifies the changes. The FMS must receive all modifications to the individual budget within the month when the changes occur and will monitor the new budget to assure the changes do not exceed the authorized budget amount. The Individual Support Broker and the FMS will both monitor to assure expenses are allowable expenses.

### Appendix E: Participant Direction of Services

#### E-2: Opportunities for Participant-Direction (6 of 6)

#### b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Self-direction budgets are authorized monthly. Members, regardless of delivery system (i.e., FFS members and MCO members), can make adjustments at any time within the authorized amount if services are not meeting their needs, and the ISB via the FFS or MCO delivery system is available to provide assistance. The ISB also routinely monitors expenses. The FMS also monitors the budget and notifies the ISB and the member immediately if claims are inconsistent with the budgeted amount or if the budget is consistently underutilized. When members chose self-direction they sign a consent form that explains their rights and responsibilities, including consequences for authorizing payments over the authorized budget amount.